Making Informed Choices About Doctors

A Report
By
The Advisory Committee on Public Disclosure of Physician Information

To the Secretary of Consumer Affairs and Business Regulation

April 1995

The Committee

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ACKNOWLEDGMENTS

In formulating our opinions and recommendations, the Committee had the benefit of advice from many knowledgeable and committed professionals and individuals representing a broad spectrum of interests in the health care system. To all those who testified at our public hearing, responded to our questionnaire and provided us with written comments, we extend our thanks for their contributions.

The Committee particularly notes the leadership exhibited by the Massachusetts Medical Society in its proposed legislation. We have been guided by some of their suggested reforms. Their position bodes well for the development of a cooperative effort between the medical and patient communities that will further our mutual goal of a sound health care system.

We thank our able staff, Penny Wells and Amy Stampfer, whose expertise and dedicated long hours were of immeasurable assistance to the Committee.

We thank Representative Carmen Buell for facilitating our fact-finding effort, as well as the members of the Board of Registration in Medicine for extending themselves to aid the Committee in reviewing its procedures and operations.

Lastly, we thank Secretary Douglas for the privilege and opportunity to serve the people of the Commonwealth.

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I. INTRODUCTION

The Board of Registration in Medicine ("Board") is the government agency charged with the licensure and discipline of physicians. In order to fulfill its mandate, the Board has been given broad statutory authority to collect information about physicians seeking or holding licenses. The Board currently maintains a great deal of information in its files. Through statutory and regulatory constraints, most of this information has been kept confidential and is unavailable to the public. In recent years, there has been a proliferation of managed care organizations that often require patients to select doctors from a list of physicians unfamiliar to them. Therefore, many parties, including the Board, professional health and medical organizations, as well as consumer advocates, have agreed that it is time to review the Board's policy of restricting public access to physician information.

A. Formation of the Advisory Committee on Public Disclosure of Physician Information

In December 1994, Secretary of Consumer Affairs Priscilla H. Douglas convened a special committee called the Advisory Committee on Public Disclosure of Physician Information ("Committee") to address the question of "what information to disclose and the most effective means for disclosing it . . . ." (Appendix 1) The Committee was chaired by the Honorable Albert L. Kramer, former Presiding Justice of the Quincy District Court, and included two other members: Frances H. Miller, Professor of Law at Boston University School of Law and Professor of Public Health at Boston University School of Public Health; and Dr. Aaron Lazare, Chancellor of the University of Massachusetts Medical Center and the Dean of the University of Massachusetts Medical School. At the time of his appointment, Judge Kramer stated, "It is important that the American people be able to make an informed choice about their health care providers, because the promise of better treatment and new cures through modern high-tech medicine also carries with it an element of risk. The Committee, therefore, sees its mission as exploring what information kept exclusively within the professional domain should now be released to the public domain. The challenge will be to assure public access to relevant and reliable information while preserving the degree of professional and private discretion that promotes good medical practice."

Secretary Douglas charged the Committee with the following responsibilities:

- to identify specific information consumers need to make informed choices about their doctors;
- to review the practices of other states relative to the release of information collected by their state medical boards;
- to invite members of the public and interested parties to meet with the committee to engage in a dialogue about these timely issues;
- to solicit opinions from experts in the fields of medicine, law and other professions; and finally,
- to recommend regulatory and statutory changes necessary to release to the public useful information on physicians' license application and renewal forms.

B. Proceedings of the Committee

Over the past four months, the Committee set out to meet the challenge posed by the Secretary. It held its first organizational meeting on December 21, 1994. In early January, the Committee developed a questionnaire dividing the sensitive information currently collected by the Board into six broad categories. (Appendix 2) It then invited a broad spectrum of individuals and groups representing consumers, the medical profession, and public and private agencies to respond to the questionnaire and give testimony at a public hearing. In addition, copies of the questionnaire were sent to other state boards of medicine, requesting their current disclosure policies. The Committee received a large number of responses to the questionnaire.

On February 2, 1995, the Committee convened its public hearing at the State House. The Committee heard and received testimony from individuals representing a broad range of interests, from patient advocacy groups to professional medical societies. (Appendices 3 and 4) Also, the Committee met with select members of consumer groups, professional societies, research institutions and government agencies to explore their viewpoints more extensively. Throughout the past four months, the Committee has supplemented its knowledge through review of many books, articles and empirical studies on these issues.

C. Sources of Information Reported to the Board

The Board of Registration in Medicine was established in 1894 and is one of ten agencies within the Executive Office of Consumer Affairs and Business Regulation. The Board consists of seven members, five physicians and two public members, who are appointed by the governor and who serve without compensation. The Board defines its mission as follows:

> To ensure that only qualified physicians are licensed to practice in the Commonwealth, and to support an environment which maximizes the high quality of health care in Massachusetts.

The Board has the fundamental power to determine whether applicants for licensure have the requisite education, ability and moral character to merit the issuance of a license to practice medicine. In its consideration of license applications and biennial license renewals, the Board requests a great deal of information from applicants about their education, training, employment and character. (Appendix 5) Additional information about the applicant is sent to the Board directly from third parties (e.g., schools or other state medical boards). License applications must be signed under penalties of perjury.

The Board's statutory functions were substantially expanded by the Medical Malpractice Act of 1986. This act was passed, in part, to enhance the public protection functions of the Board by significantly expanding its law enforcement powers. In addition to substantial increases in resources proposed (and realized for a few years in the late 1980s), the Malpractice Act created at the Board a "data repository" where most of its data is stored. G.L. ch. 112, § 5. Furthermore, the Act made certain entities mandated reporters. Professional medical associations are required to report disciplinary actions (§ 5B), professional liability insurers are required to report closed medical malpractice claims (§ 5C), and state agencies and their employees as well as health care providers are required to report violations of law (§§ 5D and 5F). In addition, the Board is designated to receive data from other statutorily mandated reporters: disciplinary actions from hospitals[1] (ch. 111, § 53B); and certain criminal law convictions (ch. 221, § 26); and court and malpractice tribunal findings (ch. 231, § 60B) from clerk magistrates.

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[1] Throughout this report reference to "hospitals" generally includes other health care facilities.

D. Information Held Confidential by the Board

Chapter 112, § 5 requires that information held in the data repository be maintained as confidential. However, unless there is a superseding statute dictating otherwise, such information can be released to the public by Board regulation. In general, the Board has not adopted such regulations, and therefore, most physician-specific information remains confidential.

E. Working Premises Adopted by the Committee

While the Board functions as a regulatory agency with licensing authority, another of its important responsibilities is to provide service and information to consumers. In furtherance of its licensing functions to determine if a doctor is qualified to practice medicine, the Board exercises its powers to obtain sensitive information from physicians and other sources. This raises serious questions about what type of information obtained for *this* purpose should be released to the public for the purpose of helping them select doctors, and what criteria should guide the Board in making that determination. In considering which of the different types of data held by the Board should be released, the Committee adhered to the following principles to guide it:[2]

1. All *reliable* information in the Board's possession that could be helpful to the public in choosing doctors should be released, unless there is a compelling public policy reason for keeping it confidential; and

2. Judgments and other dispositions regarding a physician's competency, which result from adversarial or due process proceedings, provide reasonably reliable information.

After careful review, it is the Committee's opinion that the Board has leaned too far on the side of protecting the confidentiality of its records. We believe that the Board ought to take a fresh look at the information it collects and share a greater portion of it with the public it is chartered to serve.

The Committee's findings and recommendations are detailed in Chapter II of this report. Part A of Chapter II discusses six broad categories of physician-specific information held by the Board that the Committee recommends be released to the public.

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[2] We particularly appreciate the testimony given by George Annas, J.D., M.P.H., health law professor, Boston University School of Public Health, David A. Swankin, J.D. president, Citizen Advocacy Center, and Mark R. Yessian, Ph.D., Regional Inspector General for Evaluation and Inspections, Office of Inspector General, which helped us formulate these guiding principles.

Within each category, the Committee has included an explanation of the source of the information, its recommendations regarding disclosure, and the reasoning behind those recommendations.

Part B of Chapter II discusses the relationship between the Board and the consumer, or how the information should be released to the public to assure that there is wide distribution of accurate information. The Committee believes that the Board has an obligation to both physicians and consumers to release the data in a responsible manner, i.e., to release information that is accurate, reliable and placed in context.

Finally, in Chapter III we speak briefly about recommendations for future avenues to be explored by the Board as it seeks to serve the consumers of the Commonwealth.

II. COMMITTEE FINDINGS AND RECOMMENDATIONS

A. Physician-Specific Information To Be Released

1. Medical Malpractice

Introduction

The Board currently receives information about malpractice claims and settlements from three sources. Under G.L. ch. 231, § 60B,[3] clerks of courts must report to the Board the findings of any medical malpractice tribunal. Clerks must also report any "judgment, settlement or other final disposition" in malpractice actions. The Board makes this information available to the public, but reporting by the courts is sparse and incomplete and the information is only released to the public upon request. The Board currently does not have an affirmative policy or procedure to disseminate even this category of medical malpractice information effectively.

The greatest amount of medical malpractice information concerning physicians is contained in reports of final disposition of malpractice claims reported to the Board by

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[3] "Whenever the [medical malpractice] tribunal makes a finding, the clerk of the court shall, no later than fifteen days after such finding, send a copy of the complaint and finding to the board of registration in medicine.

Upon entry of judgment, settlement, or other final disposition at trial court level, the clerk shall, no later than fifteen days after such entry, send a copy of the judgment, settlement or other final disposition, to the board of registration in medicine. The terms of such judgment, settlement, or other final disposition shall not be sealed by agreement of the parties or by any other means and shall be available for public inspection, except however, the identity of the plaintiff may be kept confidential by the board." G.L. ch. 231, § 60B.

insurance companies.[4] G.L. ch. 112, § 5C.[5] Closed claims are reported whether or not a civil complaint is filed in court. The reports state the amount of the settlement and explain the manner of disposition, including whether the claim was closed without payment. While court records containing medical malpractice dispositions are available to the public for inspection, insurance company reports are held in the Board's data repository and maintained as confidential.

Finally, physicians themselves are required to report to the Board information about malpractice claims, settlements and verdicts on their licensing applications and biennial renewal forms. The information obtained in this manner includes pending as well as closed claims and malpractice actions filed in other states. This information is currently held in the data repository and kept confidential pursuant to Board regulation.

Discussion

Public release of malpractice data is highly controversial. Physicians frequently oppose release of malpractice data on two grounds: first, physicians argue, malpractice history does not correlate directly with physician competence; and second, release of malpractice data will unfairly prejudice a physician's reputation because the public does not appreciate this lack of correlation. They also maintain that the release of such information violates their right to privacy. Consumers, on the other hand, argue that a physician's malpractice history is relevant and useful information to make informed choices about their health providers. They argue that the policy of withholding such

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[4] The term "insurance companies" in this context both here and throughout the report is intended to include risk management organizations who provide malpractice insurance coverage. G.L. ch. 112, § 5C, *infra* note 5.

[5] "Every insurer or risk management organization which provides professional liability insurance to a registered physician shall report to the board any claim or action for damages for personal injuries alleged to have been caused by error, omission, or negligence in the performance of such physician's professional services where such claim resulted in:

(a) A final judgment in any amount,

(b) A settlement in any amount, or

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the board no later than thirty days following the occurrence of any event listed in paragraph (a), (b), or (c)." G.L. ch. 112, § 5C.

Any physician without professional liability insurance must report settlement or arbitration award of his/her malpractice claims within thirty days after the settlement agreement has been reduced to writing or thirty days after service of the arbitration award on the parties and signed by all the parties. Failure of the physician to comply with the provisions of this section is punishable by a fine of up to five hundred dollars. Knowing and intentional failure to comply with the provisions of this section, or conspiracy or collusion not to comply with the provisions of this section, or to hinder or impede any other person in such compliance is punishable by a fine of between five thousand and fifty thousand dollars. G.L. ch. 112, § 5E.

information on the basis that they will give it undue weight is condescending and disingenuous.

After weighing both arguments carefully, the Committee can see no valid reason to deny the public access to a physician's malpractice history. However, in releasing malpractice data, the Board has an obligation to educate the public regarding the proper weight such data should be given in a patient's overall judgment of a physician's performance. In order to discharge this obligation, we believe the Board should: 1) provide explanatory materials discussing the caveats in interpreting the data as it relates to competency; 2) explain settlement practices, e.g., "nuisance settlements;" and 3) place an individual's malpractice history in context by comparing physicians within particular specialties.

Medical malpractice data was considered highly relevant to the Board's mission when the Legislature passed the Medical Malpractice Act of 1986. Under that law, the Board was to become a central repository for all medical malpractice data in the state. The Legislature believed at that time that malpractice information was a key indicator of substandard performance and that the Board should have access to and pursue this information in performing its public protection function.

In the time since 1986, a great deal of research has been conducted to identify indicators of substandard care among physicians. Several studies raise issues about how accurately current malpractice data correlates with competence. In their seminal report, the researchers in the Harvard Medical Practice Study state that their findings support "recent comments about the limited usefulness of the rate of claims as an indicator of the quality of care."[6] They state that "[u]nless there is a strong association between the frequency of claims and that of negligence, the rate of claims alone will be a poor indicator of quality because rates can easily vary widely at the same underlying frequency of negligence or adverse event."[7] Researchers examining various aspects of medical malpractice lawsuits among Florida physicians found that "[s]ome but not all of [their] findings [were] consistent with the view that physicians with adverse experience are competent physicians."[8] Because of these and other similar findings, the medical community is concerned that any raw data released will be misconstrued by the public.

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[6] Localio et al, *Relation Between Malpractice Claims and Adverse Events Due To Negligence, Results of the Harvard Medical Practice Study III*, N. ENGL. J. MED. 1991;325:245-51, 249 (citing Office of Technology Assessment. The quality of medical care: information for consumers. Washington, D.C.: Government Printing Office, 1988:121-41. (SUDOC no. Y3.T22/2:2 M46/12)).

[7] *Id.* at 249 (citing Sloan et al, *Medical malpractice experience of physicians: predictable or haphazard?* JAMA 1989;262:3291-7).

[8] Sloan et al, *Medical malpractice experience of physicians: predictable or haphazard?* JAMA. 1989;262:3291-7, 3297. See also Rolph et al, *Malpractice Claims Data as a Quality Improvement Tool*, JAMA. 1991;266:2093-2097 (use of physicians' malpractice claims histories to target individuals for education or sanctions is problematic because of only the modest predictive power of such claims histories).

On the other hand, some of the literature *does* show a relationship between physicians' malpractice claims history and later claims.[9] Studies also have demonstrated that malpractice claims indicate something about the quality of interpersonal care and the nature of the doctor-patient relationship.[10] Physicians frequently sued are often perceived by their patients as hurried, uninterested and unwilling to listen and answer questions. In addition, malpractice data can be used to identify problem-prone clinical processes and suggest interventions that may reduce negligence.[11] A recent report by the US Office of Technology Assessment suggests that malpractice information available from the National Practitioner Data Bank, which collects malpractice information nationwide, might be validly used for quality screening purposes by hospitals, licensing boards, and others.[12]

From a practical perspective, malpractice histories are currently collected and considered important data by most entities that license, accredit or hire physicians. At a minimum, a malpractice "outlier" will trigger further investigation by these organizations. The Board collects and analyzes malpractice data at the time of initial application and throughout a licensee's career. An applicant for licensure with a significant malpractice history will be investigated further prior to grant of a license. Similarly, a notable accumulation of malpractice payouts on the part of a licensee will trigger referral of the case to the Enforcement Division for investigation. Malpractice liability insurance companies use malpractice data when "experience rating" premiums and deciding whether an applicant for coverage is insurable.[13] Hospitals and HMOs receive malpractice data in their credentialing and recredentialing process. Lastly, we note that approximately 80% of the inquiries registered by the National Practitioner Data Bank were from managed care plans. All these health care entities clearly recognize that malpractice payouts, which may indicate findings of substandard care in a doctor's history, are important data that must be factored into the equation when evaluating a physician's performance. We feel that, with proper education and explanation, consumers are as capable of using malpractice information as responsibly as these health care entities in making their own choices about doctors.

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[9] See Bovbjerg and Petronis, *The Relationship Between Physicians' Malpractice Claims History and Later Claims*, JAMA. 1994;272:1421-1426.

[10] See Hickson et al, *Obstetricians' Prior Malpractice Experience and Patients' Satisfaction With Care*, JAMA. 1994;272:1583-1587 (physicians who have been sued frequently are more often the objects of complaints about the interpersonal care they provide even by their patients who do not sue).

[11] See Kravitz et al, *Malpractice Claims Data as a Quality Improvement Tool, I. Epidemiology of Error in Four Specialties*, JAMA. 1991;266:2087-2092.

[12] *The Quality of Medical Care: Information for Consumers*. Washington, DC: US Office of Technology Assessment; 1988.

[13] Bovbjerg and Petronis, *supra* note 9, at 1425.

To this end, we suggest charting all malpractice awards, judgments, and settlements for every physician licensed by the Board. The physicians should be grouped by specialty so that meaningful and fair comparisons may be made easily. Release of the chart must be accompanied by a discussion of the norms for each specialty, the deviations from such norms, and the reasonable conclusions that can be drawn from the information presented. Also, there should be some discussion why physicians in particular specialties and subspecialties, such as obstetricians and orthopedic surgeons, are sued more often simply because of the nature of their practices.

The chart should identify those settlements made with an insurance carrier, and those resulting from court judgments or arbitration awards. Amounts of settlements should be categorized in at least three groups, labeled "minor," "medium," or "major," with actual category ranges to be determined by the Board. Release must define and explain "nuisance" settlements (settlements reached by an insurance company for purely economic reasons unrelated to the validity of a claim) and the fact that, in many instances, doctors may not have singular control over the way their cases are handled.[14]

We recommend releasing data about settlements because we believe that the amount of a settlement says something about the credibility of the allegations and the strength of the evidence in a case. For example, claims usually do not settle for $ 500,000 if negligence is unlikely to be found by a jury. However, a claim may settle for $ 10,000 if the cost of a trial would exceed that amount. We believe consumers are capable of appreciating that a token settlement amount may simply indicate a practical decision on the part of the insurance company to avoid the substantial cost of litigation, rather than a determination of physician negligence.

We recommend that *pending* malpractice claims not be disclosed to the public. Unlike judgments and settlements that survive tests of adversarial or due process proceedings, complaints are mere accusations and, as such, are not reliable indicators of substandard care. As noted, *pending* medical malpractice claims are required to be reported to the Board on a physician's license application. We believe that without disclosing this information the public is nonetheless protected because the Board can investigate the details of multiple pending claims against a doctor. The Board can then make its own determination whether substandard care concerns resulting from these accusations are valid and warrant licensure denial or restriction. If such disciplinary action is taken, the information then becomes available to the public.

For purposes other than public disclosure, the Committee believes that G.L. ch. 112, § 5C should be amended to require insurers to report to the Board *pending* malpractice claims as well as dispositions. These reports would assist the Board in cross-

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[14] For example, there should be some discussion of why a chief resident may have numerous claims when, in fact, he/she was not directly involved with the patients' care.

checking the accuracy of physician reporting of claims. Also we note that there are no effective sanctions if insurers fail to comply with their reporting obligations. While there is no reason to believe insurance companies are not complying with their reporting responsibilities at this time, as a matter of good enforcement practice, the above § 5C should be amended to allow the imposition of an appropriate fine for noncompliance.

Recommendations

AS A MATTER OF PUBLIC POLICY:

The Committee believes that reliable medical malpractice information about a physician should be made available to the public. Specifically, the Committee recommends that the Board disclose to the public the following:

1. **all medical malpractice court judgments and amounts;**
2. **all medical malpractice arbitration awards and amounts; and**
3. **all medical malpractice insurance settlements and amounts.**

Dispositions should not be reported in specific dollar amounts; rather, they should be reported in at least three graduated categories suggesting the level of significance of the award or settlement [e.g., 1) minor, 2) medium, and 3) major].

Medical malpractice information should be reported fairly and in context by comparing physicians within their particular specialties.

***Pending* malpractice claims should not be disclosed to the public. Unlike judgments or settlements that survive tests of adversarial or due process proceedings, complaints are mere accusations and standing alone are not reliable indicators of substandard care. These should be left to the Board to investigate as a function of its licensing and disciplinary responsibilities.**

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

The Board's regulations be amended to release the above medical malpractice information (1) received from physicians on their license applications, and (2) received from insurance companies.

The Board meet with the Chief Administrative Judge of the Trial Court to establish effective procedures to ensure that courts report all medical malpractice dispositions to the Board as required by statute.

2. Hospital and Health Care Facility Reporting

Disciplinary Actions

Introduction

The Board requests information on its license application and biennial renewal forms about charges pending and disciplinary actions taken by a variety of entities: employers, other state boards, professional societies, specialty certification boards, and state and federal agencies, among others. This information is retained as confidential in the data repository. Section 53B of chapter 111 requires that hospitals and certain other health care institutions licensed by the Department of Public Health (DPH) report to the Board whenever they take certain disciplinary actions against physicians for reasons related to their competence. The Board has promulgated regulations further defining "disciplinary action" and extending the obligation to report to the full spectrum of health care facilities. 243 CMR 3.02. Reports from health care facilities are kept confidential and must be made on forms developed by the Board.

Discussion

In 1986, the Legislature passed the Medical Malpractice Reform Act, giving the Board of Registration in Medicine authority to collect information from a variety of sources concerning disciplinary action taken against physicians, and to use this information to pursue its own disciplinary actions against doctors who have engaged in substandard care or are otherwise unfit to practice medicine. The statutory amendments made at that time directed health care facilities licensed by the Department of Public Health to report to the Board when the facility "denies, restricts, revokes, or fails to renew staff privileges, or accepts the resignation of, any physician . . . for any reason related to the registrant's competence to practice medicine . . ." and for other reasons.[15] These reports must be filed within 30 days after the reportable action has occurred. Health care facilities are immune from civil liability for reports made and filed in good faith and without malice. However, according to the terms of the statute, information contained in these reports must be kept confidential, except that the Board may disclose it "only if

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[15] "Any person licensed under section fifty-one shall report to the board of registration in medicine when the licensee denies, restricts, revokes, or fails to renew staff privileges, or accepts the resignation of, any physician registered with the board as qualified to practice medicine in the commonwealth for any reason related to the registrant's competence to practice medicine or for any reason related to a complaint or allegation regarding any violation of law or regulation, of hospital, health care facility or professional medical association by-laws, whether or not the complaint or allegation specifically cites violation of a specific law, regulation or by-law." G.L. ch. 111, § 53B. See G.L. ch. 111, § 203(e) for a corollary provision for nursing homes.

doing so is necessary to enable the board to use the information in a disciplinary proceeding against the registrant." G.L. ch. 111, § 53B.

We see no justification in continuing to deny the public access to this information. Final disciplinary actions by hospitals and health care facilities are taken only after extensive procedural due process is afforded the physician and generally only when the incident is extremely serious or is consistent with a prior history of competency issues. It is therefore reliable information about a doctor's history of substandard care, and thus is relevant for the patient community to consider in selecting a physician.

Recommendations

AS A MATTER OF PUBLIC POLICY:

The Committee believes that final disciplinary actions taken against physicians by hospitals and other health care facilities should be made available to the public. Specifically, the Committee recommends that the Board disclose to the public the following:

All final disciplinary actions taken against physicians by hospitals and other health care facilities, including, but not limited to, denial, restriction or revocation of staff privileges due to incompetence or other just cause.

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

G.L. ch. 111, § 53B be amended to allow the Board to disclose to the public information contained in hospital and other health care facility final disciplinary action reports.

The Board's regulations be amended to permit disclosure of information regarding final disciplinary actions taken against a physician reported by the physician on his/her license applications.

Need For Oversight

The recent tragic reports of medication errors and mistaken chemotherapy dosages at prominent Boston teaching hospitals raise serious questions about the extent of self-regulation now left to hospitals. No clear lines of accountability to the public exist. While the above incidents were reported to the Board under the glare of the media

spotlight, the following questions continue to trouble consumers: If such an incident occurred to a member of my family, would we find out about it? How can we be sure that such mistakes will be corrected so they don't happen again? Who is watching out for patient safety? Do government regulatory agencies that are supposed to be protecting us know what really goes on in hospitals? What about questionable practices in health care institutions like HMOs, clinics, and nursing homes?

These questions bring to mind the testimony given to our Committee by Dr. Mark R. Yessian, the U.S. Regional Inspector General. Dr. Yessian suggested that the medical profession throughout the Western world must face the reality of a significant paradigm shift from a "system grounded in self regulation by the medical profession itself to one based on protecting the public." At the heart of this debate is the institution of peer review. Health care facilities, more than most institutions in our daily life, engage in the kind of constant internal review and testing, called peer review. Unforeseen events, complications, disciplinary reviews and new developments are all discussed at regular and special institutional conferences. At these sessions, those participating are expected and encouraged to speak openly and freely in the pursuit of the truth. Peer review is designed to encourage an atmosphere of full disclosure. As such, participants must be assured that their sometimes unsubstantiated and speculative contributions will not be made public. Without such assurances, the argument goes, open debate would wither and truthful discussion would be stymied.

Oversight of Disciplinary Actions

While the confidentiality of peer review proceedings remains intact, health care facilities currently are required to submit reports to the Board regarding some decisions they make. As noted, G.L. ch. 111, § 53B requires hospitals and certain health care facilities to report to the Board disciplinary actions taken against physicians. The Committee believes health care facilities have proximity to the actual delivery of care and therefore are in a favorable position to evaluate the quality of care given. These facilities have the best opportunity and expertise to monitor and judge practitioners. We believe that the legislature afforded health care facilities the confidentiality protections cited above in recognition of this preferred position and with the hope that health care facilities would take their reporting responsibilities seriously.

However, the actual success of this approach and the very real question of how well the public is being protected are difficult to gauge. At this juncture, certain information raises questions about whether health care facilities are in fact fully delivering on this expectation. No effective mechanism currently exists to determine the answer to this question.

One hundred and twenty eight (128) hospitals currently report to the Board under G.L. ch. 111, § 53B, 85 of which are acute care hospitals. In the years 1990-1993, the Board received an average of only 37.5 reports per year of disciplinary actions from these facilities.[16] In each of those years, the majority of hospitals in the state reported no disciplinary actions at all. In 1994, with 56 disciplinary reports made to the Board, only 30 of the 128 hospitals reported taking any such action against a physician.

The Massachusetts experience is not unique. A report was released in February 1995 by the Office of the Inspector General of the U.S. Department of Health and Human Services. The report described what only can be considered a dismal response by hospitals to its statutory requirement to report disciplinary actions to the National Practitioner Data Bank (Data Bank). The Inspector General found that approximately *75 percent* of the nation's hospitals had not reported a *single* adverse action to the Data Bank from its inception in September 1990 through December 1993.[17] By one measure, Massachusetts ranks 37th in the rate of its hospitals' reporting adverse actions. The reporting rate for Massachusetts is only 1.7 adverse actions per 1,000 hospital beds. The range for all states is from 8.5 to .7; the median rate is 2.5.

What do these figures mean? The Inspector General's report offers the following four possible explanations:

1) There may be few practitioners with serious performance problems.

2) Hospitals may be responding to poorly performing doctors by taking actions which are not required to be reported to the government.

3) Hospitals may be de-emphasizing or avoiding adverse actions against poorly performing doctors.

4) Hospitals may be taking adverse actions but failing to report them to the appropriate government agencies.

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[16] In its Annual Report covering the years 1990 - 1993, the Board recorded the following reports:

Hospital Discipline

Year	No. of Hospitals	No. of Doctors	Total Disciplinary Actions
1990	25	28	37
1991	23	32	33
1992	28	44	46
1993	24	31	34

[17] The Inspector General reported that the approximately 6500 hospitals in the country reported 3154 adverse actions to the Data Bank in the period 9/1/90 - 12/31/93, for an average of approximately 1000 adverse actions per year. In a planning document prepared prior to implementation of the Data Bank, the Public Health Service had estimated that 5000 reports per year would be filed. The Inspector General also notes that in the same time period, state licensing boards nationwide took disciplinary actions against about 8000 physicians.

The Inspector General concludes that there is a "basis for concern" about how hospitals are responding to reporting requirements. We too are concerned about the lack of any effective method of determining *which* of the possible explanations apply. Neither the Board nor any other independent authority is monitoring whether hospitals are taking appropriate disciplinary actions. The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the private organization primarily responsible for hospital accreditation,[18] has relegated the "review of hospital adverse actions against physicians" to a minor part of their survey process.

Currently, the statutory scheme under which hospitals report *only* final disciplinary actions does not provide any way for the Board (or any other entity) to verify independently if health care facilities are taking appropriate action. The Board does not have statutory authority to check any health care facility documentation to determine the accuracy of the facilities' reports or the appropriateness of the action taken; the Board must simply accept reports facilities submit. The Board does not have authority to examine those cases that were reviewed by hospitals where disciplinary action was not taken. Under these circumstances, it is difficult to know whether hospitals and other health care facilities are fulfilling their reporting responsibilities or, more importantly, their public protection responsibilities.

Risk Management and Quality Assurance Oversight

Legislators recognized when they passed the Malpractice Act that preventive measures in institutions might be more effective in protecting the public and keeping malpractice costs down than would disciplinary action against individual physicians undertaken either by the institution or the Board. Therefore, the Medical Malpractice Act required the Board to establish risk management programs and required physicians to participate in such programs as a condition of licensure.[19] Furthermore, hospitals and

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[18] The JCAHO is an independent non-profit organization with a board comprising members from five corporate entities (7 each from the American Hospital Association and the American Medical Association, 3 each from the American College of Surgeons and the American College of Physicians, and one from the American Dental Association) along with six public members and a nursing representative-at-large. The JCAHO has a $115 million annual budget, 71% of which is generated from accreditation survey fees from the hospitals and health care organizations. *Survey-weary hospitals drop JCAHO accreditation*, Hospital Peer Review, February 1995, Vol. 20, No.2, 26.

[19] "There shall also be established within the board of registration in medicine a risk management unit. Said risk management unit shall provide technical assistance and quality assurance programs designed to reduce or stabilize the frequency, amount and costs of claims against physicians and hospitals licensed or registered in the commonwealth. The board shall promulgate regulations requiring physicians to participate in risk management programs as a condition of licensure; provided that such regulations shall provide for an exemption from such requirements for physicians who are participating in pre-existing risk management programs that have been approved by the board." G.L. ch. 112, § 5.

nursing homes, as a condition of licensure by the Department of Public Health, must participate in risk management programs established by the Board of Registration in Medicine.[20]

As a result, in 1987, the Board promulgated its Patient Care Assessment (PCA) regulations requiring health care facilities to establish Qualified Patient Care Assessment Plans. The regulations laid out the elements of a "qualified plan" with particularity. One of the primary elements of the Board's PCA approach was the requirement that facilities report certain major incidents.

Major incidents fall into two categories: Category I and Category II. Category I incidents include: maternal deaths which are related to delivery; fetal deaths; chronic vegetative state resulting from medical intervention; and death in the course of or resulting from ambulatory surgical care. Category II incidents include: major or permanent impairments of bodily functions or deaths that are not ordinarily expected as foreseeable results of the patient's condition or of appropriately selected and administered treatment. 243 CMR § 3.08 (2)(a) and (b). The Board's theory was that by tracking a facility's response to particularly bad outcomes, the Board would be able to judge whether the facility's quality assurance program was functioning adequately to identify and address systemic faults and breakdowns. These occurrences would thus be less likely to happen again.

However, while a number of these reports are being filed, the statutory scheme provides the Board with no power or authority to guarantee their accuracy or completeness. The Board has no way of determining, for instance, whether all Category II incidents are in fact being reported,[21] or whether the facility has taken appropriate action to address any systemic faults or, if necessary, to discipline responsible physicians. Lastly, there is no current requirement for hospitals or health care facilities to report a "significant maloccurrence." An example would be a chemotherapy drug overdose where, by fortune, major or permanent injury or death did not result.

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[20] "Every licensed hospital shall, as a condition of licensure, be required to participate in risk management programs established by the board of registration in medicine pursuant to section five of chapter one hundred and twelve; provided, however, that licensed hospitals which participate in pre-existing risk management programs may be exempted by regulations of the board for the requirements of this paragraph." G.L. ch. 111, § 203(d). See §203(e) for requirements of nursing homes.

[21] The Board reported that the following numbers of major incident reports were filed from 1990 - 1993:

Year	Category I	Category II	Total
1990	433	84	517
1991	462	80	542
1992	441	81	522
1993	407	56	463

The vast majority of Category I incidents were fetal deaths. Given the broad definition of Category II incidents, we have strong suspicions that these numbers represent serious underreporting.

The Committee, mindful of the medical establishment's concerns regarding intrusion on the intimate workings of hospital administration, has struggled with the appropriate response to the dilemma. However, the current system clearly exists without any meaningful oversight to ensure patient safety, and should be changed. We do not recommend that peer review proceedings and reports be made public; we strongly believe that they should not. Rather, we suggest that steps be taken to allow some trustworthy oversight of these internal functions. We believe that the Board of Medicine, which deals on a daily basis with confidential patient and physician records and which understands physician concerns, may be the appropriate public agency to perform this function. The Board already has in place physician discipline reporting requirements for facilities, and the parallel responsibility for disciplining physicians through license action. It also has in place a commendable framework for promoting solid risk management through its PCA program. The Board is therefore in a good position to provide effective oversight with the sensitivity to professional concerns that is required. Alternatively, the Department of Public Health could perform this function since it holds the authority to license hospitals.

Discussion

The Committee's recommendations reflect the need to preserve the independence and confidentiality of the peer review system, while providing some oversight to assure accountability. As Dr. Yessian noted, ". . . the underpinnings of the self-regulation model are now giving way [to the public protection model]." This is because of another emerging reality - a system of health care more and more sensitive to financial considerations. That development necessitates that regulatory agencies have power to do their jobs in protecting the public interest effectively. We believe that granting these important, but restrained, oversight responsibilities to the Board or the Department of Public Health will enhance that protection, while preserving the medical profession's primary and traditional responsibility to provide and administer health care without interference.[22]

Recommendations

AS A MATTER OF PUBLIC POLICY:

To maintain an effective system for hospitals and other health care facilities to monitor and address adverse events, the Committee believes that the peer

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[22] Traditionally, regulation of the health care field has focused on hospitals, and the Board of Medicine's regulatory scheme reflects that focus. We note, however, that powerful forces are at work in the world of health care, chiefly characterized by a shift to a managed care model. Quality oversight is even more important in this new world. While beyond the scope of this report, we urge policymakers to incorporate into any reforms a framework for monitoring physician practice in managed care plans as well as hospitals.

review process should remain confidential to the extent that deliberations should not be disclosed to the public. We do, however, recommend:

1) **hospitals and other health care facilities be required to report all dispositions in professional conduct cases whether or not there is a final determination that a disciplinary action be taken;**

2) **hospitals and other health care facilities be required to report all incidents of "significant maloccurrences" whether or not harm results, including actions taken to prevent recurrence; and**

3) **the Board be granted authority on a confidential basis to inspect internal documents of hospitals and other health care facilities to verify the accuracy and completeness of their disciplinary and incident reports.**

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

G.L. ch. 111, § 53B be amended to require hospitals and other health care facilities to report to the Board all actions taken in professional conduct cases, whether or not final discipline results.

G.L. ch. 111, § 204 and ch. 111, § 53B be amended to permit the Board access to inspect related internal documents of hospitals and other health care facilities to verify the accuracy and completeness of their disciplinary and incident reports.

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3. Criminal Charges and Convictions

Introduction

The Board receives information regarding a licensee's criminal behavior from two sources: court clerks and physicians themselves. Under G.L. ch. 221, § 26, which was passed in 1916, court clerks must report to the Board any physician who is convicted of a felony or of a crime in connection with the practice of medicine. This information is available to the public upon request. However, as is the case with malpractice judgments, the courts only sporadically report these felony convictions to the Board.

The Board also receives information about criminal charges and convictions (other than minor traffic offenses) from physicians on their license and renewal applications.

Discussion

Criminal behavior is deemed to be relevant to an individual's overall character and integrity, and therefore is pertinent in determining a physician's fitness to practice medicine. Moreover, all the criminal history information that the Committee recommends be disclosed is already available to the public through inspection of court records. We can see no justification for the Board keeping confidential information that is otherwise available to the public. To the contrary, the Board should assist the public in gaining access to information that it is already entitled to inspect.

Recommendations

AS A MATTER OF PUBLIC POLICY:

The Committee believes that information regarding a physician's criminal convictions of serious charges should be made available to the public. Specifically, the Committee recommends that the Board collect and disclose to the public the following:

1. **all convictions of felonies during the past ten years; and**
2. **all convictions of serious misdemeanors (e.g., assault and battery, larceny, etc.) during the past ten years.**

Convictions shall include *nolo contendere* pleas and cases where sufficient facts of guilt have been found and the matter has been continued without a finding (entered without a finding of guilt).

The above convictions shall be disclosed whether or not they are related to the practice of medicine.

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

G.L. ch. 221, § 26 be amended to require courts to report to the Board all convictions of felonies and misdemeanors whether or not related to the practice of medicine.

The Board's regulations be amended to release information concerning the above criminal convictions received from physicians on their licensing applications.

4. Physician Chemical Dependency

Introduction

The Board receives information on physician substance abuse from a number of different sources. G.L. ch. 112, § 5F mandates that health care providers report to the Board any physician who is reasonably believed to be chemically dependent. However, the statute allows the Board to exempt health care providers from this reporting requirement if the subject physician complies with the requirements of a Board-approved drug or alcohol program (such as the Massachusetts Medical Society's Physician Health Services), and the reporter receives direct confirmation of compliance from such a program within thirty days. This exemption is only available if no allegation of actual or threatened patient harm is made. In addition, physicians are encouraged to self-report their chemical dependency to the Board, either on the licensing forms or at any time between renewal periods.

In June 1988, the Board instituted its Chemically Dependent Physician Policy, which adopts the disease model for chemical dependency while acknowledging that patient safety is of paramount importance. When a chemically dependent physician comes to the Board's attention, the Board enters into an agreement with the physician for a comprehensive treatment and monitoring program. This usually requires abstinence from all controlled substances, random alcohol and other drug testing, a prohibition from self-prescribing controlled substances, psychotherapy and AA/support group attendance. This agreement can take one of three forms:

1. **Letter of Agreement**. In certain circumstances, the Board permits chemically dependent physicians to enter into private agreements with the Board's Complaint Committee. A physician who self-reports his dependency to the Board where there is no evidence of any patient harm or risk of patient harm may be eligible for a private Letter of Agreement. This document sets forth an understanding of the physician's rehabilitative program, but does not impose any sanction or formal probation which would be reportable to a national data bank. The physician is required, however, to disclose its existence to employers, hospitals and other licensing boards.

2. **Assurance of Discontinuance**. If a physician does not self-report, but there are no allegations of patient harm or risk of patient harm, then the Board may offer the physician the opportunity to enter into an Assurance of Discontinuance with a probation agreement. An Assurance of Discontinuance is a formal disciplinary agreement between a recovering physician and the Board and, when coupled with a probation agreement, is reportable to a national data bank. An Assurance does not require a

physician to admit or deny any facts and no formal hearing takes place. A standard period of probation is typically imposed as a sanction in these cases.

3. **Consent Order**. When a physician is not eligible for either a Letter of Agreement or an Assurance of Discontinuance, but is willing to admit to the facts, the physician may be allowed to enter into a Consent Order (with a probation agreement) with the Board. Consent Orders and accompanying Statements of Allegations constitute publicly reportable disciplinary actions. In cases where patient care has been compromised, where there has been risk of compromise, or where significant violations of law or the Board's regulations have occurred, the Consent Order is the only available option short of a full adjudicatory hearing. The Board may impose sanctions in addition to probation, including practice restrictions or a stayed suspension for the term of the monitoring agreement.

A physician may continue to practice under a Letter of Agreement, Assurance of Discontinuance or Consent Order. However, if the Board determines at any time that the physician's chemical dependency represents an immediate and serious threat to the public, it can vote to suspend the physician's license to practice medicine summarily. In addition, violation of a Probation Agreement or of the conditions of a Letter of Agreement may result in suspension of a physician's license to practice. Any suspension of a license is a publicly reportable disciplinary action.

Physician Health Services. Over the last few years, the Board has developed a close working relationship with the Massachusetts Medical Society's Physician Health Services ("PHS") (formerly Committee on Physician Health). The Board estimates that over 50% of all reports it receives come from Physician Health Services regarding physicians in PHS contracts who have violated their agreements. PHS makes quarterly reports to the Board on a physician's progress. In addition, PHS must notify the Board immediately by telephone and in writing if:

1) a physician misses any random alcohol or other drug test;

2) a physician's sample is found to contain any evidence of alcohol or any controlled substance;

3) PHS has obtained other reliable evidence that the physician has used alcohol or any other controlled substance; or

4) a physician fails to comply with any other conditions of the program.

Discussion

Chemical dependency among licensed physicians is a very serious problem. The Board estimates that one-third of its disciplinary cases in a typical year involve chemically dependent physicians. The AMA estimates that as many as 7% to 10% of physicians are chemically dependent at some time during their careers. Other estimates run as high as 12% to 14%.

Many consumers responding to our survey expressed strong interest in knowing whether their physicians have substance abuse problems. At the same time, physicians obviously consider this information highly confidential. Physicians in recovery are patients themselves and feel that they should receive the same confidentiality considerations afforded other patients.

While we recognize the interest of consumers in having this information, we think that long-standing tradition and conventional wisdom to cloak those in treatment with anonymity should prevail in this case. Therefore, we recommend that information concerning a doctor's recovery from chemical dependency that is not the subject of disciplinary action remain confidential. To do otherwise would discourage physicians from self-reporting and seeking treatment, and would chill reporting of chemical dependency by their colleagues.

However, in recommending that doctors be afforded the same confidentiality in their recovery as are other patients, it must be remembered that doctors are nonetheless not like most patients because they have special responsibilities. Their performance as medical practitioners can sometimes mean the difference between a patient's good health or debilitation. Confidentiality can only be afforded as long as proper safeguards assure minimal patient risk while a physician undertakes his or her recovery.

We have examined the PHS program model and are impressed with its plan for lengthy (five years), comprehensive and intensive treatment. We are also impressed with the qualifications and commitment of the administrator and staff. However, time and available resources did not afford the Committee an opportunity to assess fully how tightly physician-patients are monitored. Nor could we determine the extent to which noncompliance is met with appropriate sanctions, including restrictions on medical practice. Our recommendations, therefore, articulate steps we believe as a matter of policy are necessary to ensure public safety.

Recommendations

AS A MATTER OF PUBLIC POLICY:

The Committee believes that information concerning a physician's chemical dependency that is not the subject of disciplinary action should be confidential provided that the physician is successfully undergoing or has successfully completed

a Board-approved treatment program and continues to maintain his/her sobriety. In order to guarantee public safety:

1) **the Board should conduct an annual review of all approved treatment programs with respect to their efficacy in monitoring and enforcing physician compliance;**

2) **attendance at required AA meetings should be monitored in accordance with current practices accepted by the AA community;**

3) **the Board and/or PHS should conduct an assessment and make written findings concerning whether it is safe for the physician to practice without limitation during the initial stages of recovery, or whether some restrictions should be imposed until the physician demonstrates a sufficient track record of sobriety; and**

4) **if the physician-patient resumes the use of alcohol or drugs or violates any other material condition of the program, the Board should conduct an immediate disciplinary hearing to determine whether restrictions on the physician's practice of medicine should be imposed. The only exception to an automatic disciplinary hearing would be if any infraction or "slippage" was self-reported by the doctor and the doctor agreed a) to enter more intensive treatment, such as an in-patient program, and b) to sign a voluntary agreement for appropriate medical practice restrictions.**

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5. Medical Education and Post-Graduate Training

Introduction

As part of its licensing function, the Board acquires extensive information regarding a physician's premedical and medical education (e.g., school(s) attended and years of attendance) and certification of post-graduate training (e.g., internships, residency and fellowship programs). This information is available to the public upon request.

Discussion

The Board is responsible for determining whether an applicant is qualified to practice medicine in the Commonwealth. In order to do so, the Board must examine an applicant's entire record. We believe that the Board must have access to this type of

information in order to perform its licensing functions, but it would be an unnecessary invasion of privacy to make public certain details of pre-license training. If a license application is approved, the Board has carefully considered the applicant's academic and training credentials, including any adverse events, and has judged the physician competent to practice medicine. For a patient to scrutinize academic records in detail (e.g., interruptions in education, National Board Exam scores, etc.) would provide little valuable information and would unnecessarily intrude on the physician's privacy.

The sole exception to this rule concerns expulsion, suspension, and/or forced leave of absence from a residency program. We believe consumers should have this information because it usually occurs shortly before full licensure and because it may indicate clinical performance problems.

Recommendations

The Board should disseminate factual data about a physician's education and training background to the public in an effective manner.

The Board should treat records detailing academic and training performance prior to licensure as confidential. However, the Board should disclose information about a physician's failure to complete a residency training program, where the physician has been expelled, suspended or invited to take a leave of absence due to competency or character concerns, under circumstances where procedural due process was afforded the physician.

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6. Employment and Credentialing Information

Introduction

Employment and Credentialing History. A great deal of factual information about a physician's licensure and employment is currently collected by the Board, including out-of-state medical licenses, current and past hospital privileges, health care facility affiliations, areas of specialty, and specialty board certifications. Disclosure of this type of physician-specific employment and credentialing information is currently not published. The public can only obtain information about a physician's special qualifications by specific request.

Employment and Credentialing Restrictions. The Board collects additional information about a physician's relationship and history with other licensing authorities, employers and health care facilities at which he or she sought or held privileges. Most of

this information is currently held confidential. Among the items collected are withdrawal or denial of application for licensure in another state or for privileges at a hospital, voluntary surrender of a license or privileges, denial of recertification or loss of American Specialty Board certification, and resignation from a medical staff. The Board also collects information concerning voluntary modification or limitation of scope of practice for reasons other than a medical condition, restrictions on or denial of third party payor participation or enrollment, and reports of violations of law by health care provider peers.

Discussion

Certainly the most important source of information about a physician's medical performance is his or her licensing and employment history. Information regarding the nature and number of years in practice, other states in which the physician has practiced, advanced training and specialty board certification, health care facilities where physicians hold privileges, faculty appointments, articles and books published, and honors and awards can tell consumers a great deal about a doctor's qualifications. In fact, we believe that the Board could and should collect more demographic data, in order to provide consumers with a more complete physician profile.[23] Therefore, employment and credentialing information should be published and not just made available upon request.

Recommendations

Physician-specific employment and credentialing history of his or her practice of medicine should be released in published form. (See section entitled "Creation of Physician Profiles").

The Board should disclose any restrictions on a physician's license or privileges, such as:

1) **the surrender of a physician's medical license or privileges in any state whether or not voluntary, if considered by the licensing or privilege-granting entity to be a disciplinary action;**

2) **a physician's resignation from practice in a particular state or from a medical staff if the resignation is considered a disciplinary action, or if it was offered to avoid investigation or disciplinary action;**

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[23] The Massachusetts Medical Society recommended several areas that might be appropriate for the Board to explore, including years in practice, appointments to medical school faculties and responsibilities for graduate medical education, number and nature of peer-reviewed literature, involvement in clinical research, and professional or community service activities and awards.

3) **the denial of a medical license in any state for any reason; and**

4) **restrictions on or denial of participation or enrollment because of issues related to competency or character in a system where a third party pays all or part of a patient's bill.**

B. Methods of Release

Virtually all of those testifying before this Committee, and particularly representatives of consumer interest groups, emphasized the responsibility of the Board to *facilitate* public access to its data. This task involves two elements: first, creation of lines of communication between the Board and consumers to help consumers know what information exists at the Board; and second, provision of background and context to help consumers understand and use Board information more effectively. We note that nurturing an informed and educated consumer ultimately will benefit both provider and patient. The more reliable information patients receive, the more responsible and intelligent they will be in making their own decisions.

This section of the report presents the Committee's recommendations about ways in which the Board can present its data so that consumers are better served.

1. Creation of Physician Profiles

The Committee believes that to release adverse information (e.g., a negative malpractice history) in isolation would tend to magnify and exaggerate the importance of an adverse event in what may be an otherwise unblemished career of accomplishments. Therefore, the Committee recommends that the Board create a "Physician Profile" containing essential information about a physician's education, training, employment and character. This type of format will provide the patient community with a ready reference to a particular doctor.

"Physician Profile" means different things to different people. We do not mean a "report card" on a physician comparing his/her performance in a particular procedure or field to other similarly-situated physicians. As we discuss in Chapter III, "Looking To the Future- Outcomes Measurements," we do not believe that existing research or data permit a meaningful comparison of physicians based on outcomes, such as mortality and complication rates. Rather, we have a much more practical meaning in mind when we refer to "physician profile."

The Committee has recommended public disclosure of many types of information collected by the Board in this report. We believe, however, that there is a difference between making this information available to consumers on request and actually publishing and disseminating summary information about physicians. We urge the Board to discharge its responsibilities by performing an important function for both consumers and physicians by compiling and distributing a directory of Massachusetts physicians. In such a directory, "snapshot" information about the physician would be presented, including, among other valuable information, elements most likely to be important to patients.

In addition, to release adverse information (e.g., a negative malpractice history) in isolation would tend to magnify and exaggerate the importance of an adverse event in what may be an otherwise unblemished career of accomplishments. Therefore, it is important that the release of adverse history be made in context of a profile detailing the physician's qualifications and achievements.

Josh Kratka, Staff Attorney at MASSPIRG, a consumer protection organization, testified at the public hearing that a "profile" should not include all information publicly available about a physician. He recommended that "to avoid information overload, only the most significant elements of a physician's record should be routinely included." We concur.

Below is a sample of the type of information that should be included in the profile:

Name

Office phone number(s) and address(es)

Nature of practice (group practice, solo practice, hospital staff)

Number of years in practice

Medical license status

Premedical and medical schools, years attended and degrees awarded

Postgraduate training

Specialty

American Specialty Board certification and recertification, and eligibility for certification

Current employment, including faculty appointments

Health care facilities where physician holds privileges

Plans in which physician is a provider

Refereed journal articles and book chapters

Honors and awards

Board or hospital disciplinary findings

Criminal charges/convictions

Malpractice summary (compared with norm for specialty)

2. Accurate Information

The Board should take all steps necessary to assure that the information which it releases to the public about individual physicians is accurate and complete.

The Board obtains sensitive information about physicians through its power as an agency of the state, and holds that information in public trust. When the Board discusses sharing this information with the public at large, the burden on the Board not to make mistakes is considerable. In some circumstances, a physician's reputation, perhaps even his or her career, may be on the line.

In testimony at the Committee's public hearing, we heard that the data currently held in the Board computer system contains flaws, even in such mundane areas as address and zip code. The Board must make exhaustive efforts prior to release to assure the integrity of its data. We expect that if our recommendations are adopted, the Board will incorporate new data elements into its computer system. We encourage the Board to establish tight controls to check the validity of each entry. Not only could the release of incorrect or incomplete data potentially harm an individual physician, but it could also damage the Board's credibility as a source of sound information for consumers.

The Board should provide the individual physician with a copy of the physician profile in advance of its availability to the public so that the physician may correct factual inaccuracies.

One way that the Board can obtain a check on the material it plans to release to the public is to provide a "galley" of the physician profile to each physician prior to release. The physician would review the profile for mistakes and inaccuracies, which the Board would enter into the computer system when appropriate. The profiles should be updated by the Board at least once every two years when the physician renews his or her license and should be shared with the physician at that time.

Physicians should have access as a matter of course to any information the Board maintains and makes available to the public, whether or not it is included in the physician profile.

We carefully considered but rejected the idea of giving the physician an opportunity to provide an explanation of any elements in his or her file. We are aware that the National Practitioner Data Bank does allow physicians to include an explanation of up to 600 characters in their files. However, we believe that any benefits derived from permitting such explanations are outweighed by the need to prevent information overload. In addition, we believe that much of the data released by the Board is purely factual and statistical, and therefore not subject to manipulation by the Board prior to release. We note that when answering questions on their renewal forms, physicians are required to provide explanations in many situations. Under our recommendations, these explanations would be available to the public on request.

The Board has an obligation to place in context any information about a physician which may be confusing or subject to differing interpretations.

"Physicians are often concerned that consumers will be confused and/or misled by information made available to them. Instead of addressing those concerns by making little information available, it would be preferable to make more information available but in ways that help the public interpret it properly." We agree with this testimony from Dr. Yessian. The way to address problems raised through release of potentially misinterpreted data is to educate the public to place this information in context. By doing this, the Board provides consumers with tools that they may use in evaluating health care delivery systems, fosters a more cooperative and communicative relationship between physicians and consumers, and dissipates any mistrust that physicians and the Board are participating in hiding information to protect the medical profession.

We have already discussed this issue in the context of malpractice information, but there may be other areas where explanations are needed. We note that both physician and consumer interest groups emphasized the importance of helping consumers understand and interpret the data disclosed by the Board. At the same time, they warned that too much information may confuse rather than clarify the issues. A proper balance should and can be achieved.

3. Consumer Outreach

The Board should become an active and strong voice for consumer protection in the health care field. Its mission should include a commitment to an education and outreach program for consumers on general issues of health care delivery.

We stated earlier that the Board has a dual role as both a regulatory and information agency. Traditionally, the Board has devoted most of its resources to its regulatory functions. We think it is time for the Board to turn some of its attention to its consumer information functions.

We recognize that the Board, through budget cutbacks and an expanding work load, has had little latitude in the past few years to pursue much more than its function of licensing and disciplining doctors. The public would be (and has been) justifiably upset when it appears the Board is failing to accomplish that task. However, we encourage the Board and those responsible for setting the Board budget and priorities to invest in becoming more of a consumer advocacy agency. It can do so by organizing discussions and seminars on health topics, undertaking speaking engagements at consumer groups, participating in consumer protection initiatives that could be jointly sponsored by the Department of Public Health, and publishing brochures on topics of interest to consumers. The Board should become a respected voice for *quality* in the delivery of health care, thereby assisting both consumers and the medical profession in achieving the best possible health services for the Commonwealth.

4. Consumer Advocacy

The Board should develop vehicles to inform consumers about its operations and information it has available to them, so that the Board's services and the information it retains can be routinely utilized.

In addition to education and outreach on topics of general interest to the public, the Board should actively seek to make consumers aware of its role and mission. The Board should educate consumers about what it does, the information that is available to the Board, how one files a complaint at the Board, and the process by which complaints are handled. David A. Swankin, J.D., president of the Citizen Advocacy Center, a support program for public members of health care regulatory boards and governing bodies, testified before the Committee about his experiences with regulatory boards. Mr. Swankin reported that even when boards permit disclosure of interesting and useful information, they are "not very good at taking affirmative action to make information

available on their own initiative." We believe it is time they do so. We believe that following this course will improve the image of the Board and will help to garner consumer support for its efforts.

The Board should be accountable to the public for its performance and should make public information documenting the way it has done its job.

We agree with those who testified about the value of boards becoming accountable to the public. The most important way to be accountable is to disclose information documenting board performance publicly. Ranking state boards' performance based solely on tallies of disciplinary actions they take is crude and ultimately misleading to the public. The Board should develop a fair and sensitive "self assessment instrument" to evaluate its performance (see for example the "Self Assessment Instrument" developed by the Federation of State Medical Boards). We encourage the Board to use such an instrument and to release the results with appropriate explanations to the public. Such a step would send a strong message that the Board believes it should be accountable to the public.

C. Board's Resources and Commitment

Board's Resources

One of the fundamental principles in releasing information that has the potential of affecting a physician's reputation is that such information must be accurate and complete. Therefore, the Committee's recommendations contained in this report should not be implemented unless the Commonwealth allocates the necessary resources. To use a current political phrase, these responsibilities delegated to the Board should not go as "unfunded mandates." Therefore, any proposed budget should consider the staffing, technical support and information systems necessary to achieve the important and attainable goals outlined in the Committee's report.

Board's Commitment

Implementation of the Committee's recommendations will provide needed tools for the Board to fulfill its consumer education and protection functions. Tools and funding alone, although essential, will not bring about the strong leadership needed to

protect the public interest. These must be accompanied by a firm commitment on the part of the Board to enforce the standards that will provide maximum protection to the public.

Understandably, the Board must work closely and cooperatively with the medical establishment to improve the health care system. But it must at all times preserve its independence and be vigilant not to allow collegiality to deter it from its mission of providing objective and effective oversight of physician performance.

Whether or not the Board is now maintaining this independence, there is a growing public perception that it is not. Many consumers in Massachusetts are skeptical of the Board's commitment to enforce its regulations aggressively to protect them. We also believe that much of the skepticism results from the Board's long-standing policy of keeping most of the information in its possession confidential. We hope, therefore, that the Committee's recommendations providing for more openness will bring about a change in that policy and in the public's perception of the Board's effectiveness.

III. Looking To the Future - Outcomes Measurements

The real issue behind the Committee's work is not simply a question of what type of information the Board releases to the public. The larger, more important question is to determine how consumers can make more informed choices about the doctors to whom they entrust their physical health. This question has become even more important in an increasingly competitive health care system which is driven more and more by financial pressures. Reliable information is critical in this type of environment because true competition entails informed choices among alternatives. For *insured* patients, pricing information has little, if any, significance when choosing a doctor. Information about quality thus becomes more important if consumer choices are to be meaningful. The debate on what is the most reliable information for consumers to consider in judging a health care provider's performance has just begun.

In recent years, a great deal of work has been done by researchers across the country on the question of how to measure quality of care in some quantifiable and meaningful manner. As in other areas of service, weaknesses are best identified and improvements best recommended when based on objective, scientific data which enables comparisons among providers of those services. Under the general rubric of "outcomes studies," researchers have attempted to establish valid measurements of performance in the medical field. The efforts are driven by three complementary goals: (1) to assist consumers in deciding which physicians (or hospitals or HMOs) to choose; (2) to show

providers what works, thereby improving performance in delivering health care; and (3) to aid administrators in selecting and contracting with particular providers.

Understandably, the effort to establish valid and widely-accepted outcome measures for physicians will engender lively debate. Nevertheless, it is clear that one of the bottom lines in judging medical practitioners' or hospitals' performance lies in comparing their ability to reduce rates of mortality and unexpected complications. The task will not be easy: How do we account for patient mix in evaluating the differences among physicians? How do we evaluate the work of physicians such as family practitioners or internists, whose work is not as amenable to clear statistical comparisons as are procedures performed by surgeons?

The additional challenge of translating this information into a language that consumers can understand and use, perhaps in a format similar to a "report card," has significantly heightened tensions. Physicians have a right to be concerned that the data, which in some models include complex medical terminology, will be misunderstood and misinterpreted by consumers. Alternatively, if it is simplified, they are concerned that it will not give an accurate and fair picture. Another argument continues over the appropriate entity to collect, analyze and present this data. What should be the government's role?

We also recognize that development of a valid measuring tool by which to judge the performance of health care providers will not be immediate and will require significant research.[24] We do believe, however, that valid outcome measurements can and must be perfected. We recommend that government move to advance this endeavor. Government agencies are unconflicted about the primacy of protecting the public interest. Therefore, they have an important role to play. Its power should be directed to representing and preserving consumer interests in this important new field.

Therefore, the Committee recommends that a commission be appointed to formulate recommendations for developing working models to measure and compare mortality rates, complication rates and other performance outcomes of hospitals, and among doctors in selected specialties.

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[24] Not only are these endeavors complex, they are expensive. Pennsylvania invested $ 17 million in tracking physician performance on only <u>two</u> DRGs (diagnosis related group).

SUMMARY OF RECOMMENDATIONS

The following is a summary of the recommendations made in the body of this report.

PHYSICIAN-SPECIFIC INFORMATION TO BE RELEASED

MEDICAL MALPRACTICE

AS A MATTER OF PUBLIC POLICY:

The Committee believes that reliable medical malpractice information about a physician should be made available to the public. Specifically, the Committee recommends that the Board disclose to the public the following:

1) all medical malpractice court judgments and amounts;

2) all medical malpractice arbitration awards and amounts; and

3) all medical malpractice insurance settlements and amounts.

Dispositions should not be reported in specific dollar amounts; rather, they should be reported in at least three graduated categories suggesting the level of significance of the award or settlement [e.g., 1) minor, 2) medium, and 3) major].

Medical malpractice information should be reported fairly and in context by comparing physicians within their particular specialties.

***Pending* malpractice claims should not be disclosed to the public. Unlike judgments or settlements that survive tests of adversarial or due process proceedings, complaints are mere accusations and standing alone are not reliable indicators of substandard care. These should be left to the Board to investigate as a function of its licensing and disciplinary responsibilities.**

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

The Board's regulations be amended to release the above medical malpractice information (1) received from physicians on their license applications, and (2) received from insurance companies.

The Board meet with the Chief Administrative Judge of the Trial Court to establish effective procedures to ensure that courts report all medical malpractice dispositions to the Board as required by statute.

HOSPITALS AND HEALTH CARE FACILITY REPORTING

Disciplinary Actions

AS A MATTER OF PUBLIC POLICY:

The Committee believes that final disciplinary actions taken against physicians by hospitals and other health care facilities should be made available to the public. Specifically, the Committee recommends that the Board disclose to the public the following:

All final disciplinary actions taken against physicians by hospitals and other health care facilities, including, but not limited to, denial, restriction or revocation of staff privileges due to incompetence or other just cause.

Need for Oversight

AS A MATTER OF PUBLIC POLICY:

To maintain an effective system for hospitals and other health care facilities to monitor and address adverse events, the Committee believes that the peer review process should remain confidential to the extent that deliberations should not be disclosed to the public. We do, however, recommend:

1) **hospitals and other health care facilities be required to report all dispositions in professional conduct cases whether or not there is a final determination that a disciplinary action be taken;**

2) **hospitals and other health care facilities be required to report all incidents of "significant maloccurrences" whether or not harm results, including actions taken to prevent recurrence; and**

3) **the Board be granted authority on a confidential basis to inspect internal documents of hospitals and other health care facilities to verify the accuracy and completeness of their disciplinary and incident reports.**

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

G.L. ch. 111, § 53B be amended to allow the Board to disclose to the public information contained in hospital and other health care facility final disciplinary action reports.

The Board's regulations be amended to permit disclosure of information regarding final disciplinary actions taken against a physician reported by the physician on his/her license applications.

G.L. ch. 111, § 53B be amended to require hospitals and other health care facilities to report to the Board all actions taken in professional conduct cases, whether or not final discipline results.

G.L. ch. 111, § 204 and ch. 111, § 53B be amended to permit the Board access to inspect related internal documents of hospitals and other health care facilities to verify the accuracy and completeness of their disciplinary and incident reports.

CRIMINAL CHARGES AND CONVICTIONS

AS A MATTER OF PUBLIC POLICY:

The Committee believes that information regarding a physician's criminal convictions of serious charges should be made available to the public. Specifically, the Committee recommends that the Board collect and disclose to the public the following:

1) **all convictions of felonies during the past ten years; and**

2) **all convictions of serious misdemeanors (e.g., assault and battery, larceny, etc.) during the past ten years.**

Convictions shall include *nolo contendere* pleas and cases where sufficient facts of guilt have been found and the matter has been continued without a finding (entered without a finding of guilt).

The above convictions shall be disclosed whether or not they are related to the practice of medicine.

TO IMPLEMENT THE ABOVE, WE RECOMMEND:

G.L. ch. 221, § 26 be amended to require courts to report to the Board all convictions of felonies and misdemeanors whether or not related to the practice of medicine.

The Board's regulations be amended to release information concerning the above criminal convictions received from physicians on their licensing applications.

PHYSICIAN CHEMICAL DEPENDENCY

AS A MATTER OF PUBLIC POLICY:

The Committee believes that information concerning a physician's chemical dependency that is not the subject of disciplinary action should be confidential provided that the physician is successfully undergoing or has successfully completed a Board-approved treatment program and continues to maintain his/her sobriety. In order to guarantee public safety:

1) **the Board should conduct an annual review of all approved treatment programs with respect to their efficacy in monitoring and enforcing physician compliance;**

2) **attendance at required AA meetings should be monitored in accordance with current practices accepted by the AA community;**

3) **the Board and/or PHS should conduct an assessment and make written findings concerning whether it is safe for the physician to practice without limitation during the initial stages of recovery, or whether some restrictions should be imposed until the physician demonstrates a sufficient track record of sobriety; and**

4) **if the physician-patient resumes the use of alcohol or drugs or violates any other material condition of the program, the Board should conduct an immediate disciplinary hearing to determine whether restrictions on the physician's practice of medicine should be imposed. The only exception to an automatic disciplinary hearing would be if any infraction or "slippage" was self-reported by the doctor and the doctor agreed a) to enter more intensive treatment, such as an in-patient program, and b) to sign a voluntary agreement for appropriate medical practice restrictions.**

IN ADDITION, WE RECOMMEND THE FOLLOWING:

MEDICAL EDUCATION AND POST-GRADUATE TRAINING

The Board should disseminate factual data about a physician's education and training background to the public in an effective manner.

The Board should treat records detailing academic and training performance prior to licensure as confidential. However, the Board should disclose information about a physician's failure to complete a residency training program, where the physician has been expelled, suspended or invited to take a leave of absence due to competency or character concerns, under circumstances where procedural due process was afforded the physician.

EMPLOYMENT AND CREDENTIALING

Physician-specific employment and credentialing history of his or her practice of medicine should be released in published form. (See section entitled "Creation of Physician Profiles").

The Board should disclose any restrictions on a physician's license or privileges, such as:

1) **the surrender of a physician's medical license or privileges in any state whether or not voluntary, if considered by the licensing or privilege-granting entity to be a disciplinary action;**

2) **a physician's resignation from practice in a particular state or from a medical staff if the resignation is considered a disciplinary action, or if it was offered to avoid investigation or disciplinary action;**

3) **the denial of a medical license in any state for any reason; and**

4) **restrictions on or denial of participation or enrollment because of issues related to competency or character in a system where a third party pays all or part of a patient's bill.**

METHODS OF RELEASE

Creation of Physician Profiles

The Committee believes that to release adverse information (e.g., a negative malpractice history) in isolation would tend to magnify and exaggerate the importance of an adverse event in what may be an otherwise unblemished career of accomplishments. Therefore, the Committee recommends that the Board create a "Physician Profile" containing essential information about a

physician's education, training, employment and character. This type of format will provide the patient community with a ready reference to a particular doctor. Below is a sample of the type of information that should be included in the profile:

- **Name**
- **Office phone number(s) and address(es)**
- **Nature of practice (group practice, solo practice, hospital staff)**
- **Number of years in practice**
- **Medical license status**
- **Premedical and medical schools, years attended and degrees awarded**
- **Postgraduate training**
- **Specialty**
- **American Specialty Board certification and recertification, and eligibility for certification**
- **Current employment, including faculty appointments**
- **Health care facilities where physician holds privileges**
- **Plans in which physician is a provider**
- **Refereed journal articles and book chapters**
- **Honors and awards**
- **Board or hospital disciplinary findings**
- **Criminal convictions**
- **Malpractice summary (compared with norm for specialty)**

<u>Accurate Information</u>

In disclosing information to the public, the Board is obligated to take all steps necessary to assure that the information which it releases to the public about individual physicians is accurate and complete. The Board should provide the individual physician with an advance copy (a galley) of any information intended to be published so that the physician has an opportunity to correct factual inaccuracies.

<u>Interpreting the Data</u>

To insure that the information disclosed is reported in a fair manner, the Board should provide explanations and interpretations of the information being released, e.g.,

1) **medical malpractice information should be released in specialty comparison format;**

2) data concerning settlement of malpractice claims should be discussed in light of current tort system realities of settlement practice; and

3) specialty certification procedures should be explained.

Consumer Outreach

The Board should become an active and strong voice for consumer protection in the health care field. Its mission should include a commitment to an education and outreach program for consumers on general issues of health care delivery.

Consumer Advocacy

The Board should develop vehicles to inform consumers about its operations and information it has available to them, so that the Board's services and the information it retains can be routinely utilized.

The Board should be accountable to the public for its performance and should make public information documenting the way it has done its job.

BOARD'S RESOURCES AND COMMITMENT

Resources

We recommend that the responsibilities delegated to the Board should not go as "unfunded mandates." Therefore, any proposed budget should consider the staffing, technical support and information systems necessary to achieve the important and attainable goals outlined in the Committee's report.

Commitment

The Board believes that tools and funding alone, although essential, will not bring about the strong leadership needed to protect the public interest. These must be accompanied by a firm commitment on the part of the Board to enforce the standards that will provide maximum protection to the public.

Looking to the Future - Outcomes Measurements

The Committee believes that one of the bottom lines in judging a medical practitioner's or a hospital's performance lies in comparing their ability to reduce rates of mortality and unexpected complications. Therefore, the Committee recommends that a commission be appointed to formulate recommendations for developing working models to measure and compare mortality rates, complication rates and other performance outcomes of hospitals, and among doctors in selected specialties.

APPENDICES

APPENDICES

APPENDIX 1:

Press release announcing formation of the Advisory Committee on Public Disclosure of Physician Information

Commonwealth of Massachusetts
Executive Office of Consumer Affairs
One Ashburton Place
Boston, Massachusetts 02108

617 / 727-7755

WILLIAM F. WELD
GOVERNOR

RGEO PAUL CELLUCCI
LIEUTENANT GOVERNOR

RISCILLA H. DOUGLAS
SECRETARY

FOR IMMEDIATE RELEASE
Monday, December 6, 1994

Contact: Terry Ann Knopf
(617)727-7755

JUDGE ALBERT L. KRAMER TO HEAD PUBLIC DISCLOSURE ADVISORY COMMITTEE
Group to Recommend Administrative and Legislative Changes on Public Access to Information on Physicians

Massachusetts Secretary of Consumer Affairs Priscilla H. Douglas today announced the creation of a three-member Public Disclosure Advisory Committee to evaluate what physician information the Board of Registration in Medicine should provide to the public.

Secretary Douglas said: "The Board of Registration in Medicine presently collects a great deal of information directly from physicians on their license application and renewal forms. "However, most of the information remains confidential because of various statutes and regulations," she said, adding: "There is growing sentiment by the Board, professional health and medical organizations and consumer advocates that more information should be available to the public. What information to disclose and the most effective means for disclosing it remains the sticking point. The goal of the Public Disclosure Advisory Committee is to address and resolve this central issue."

Secretary Douglas named Albert L. Kramer, former Presiding Justice of the Quincy District Court, chairman of the committee. "Judge Kramer has had a distinguished career in both law and government, and brings with him a record of sound and effective public policy innovations which have gained local and national, attention," she said.

Judge Kramer will be joined by two other distinguished committee members: Frances H. Miller, who holds a dual appointment as a professor of law at the Boston University School of Law and professor of public health at the Boston University School of Medicine; and Dr. Aaron Lazare, Chancellor of the University of Massachusetts Medical Center and Dean of the University of Massachusetts Medical School.

(more)

Judge Kramer stated: "The one clear consensus that has emerged from the national debate on health care is that the American people want a system that permits them to choose their own doctors. It is important that this be an informed choice, because the promise of better treatment and new cures through modern high-tech medicine also carries with it an element of risk. Therefore, it is understandable why a demand has been created in the patient community for more access to information, including the risks of treatment.

"The committee therefore sees its mission as exploring what information to date kept exclusively within the professional domain should now be released to the public," said Judge Kramer. "The challenge will be to assure public access to relevant and reliable information while preserving the degree of professional and private discretion that promotes good medical practice."

Secretary Douglas announced that Judge Kramer will convene the first committee meeting later this month. The committee's responsibilities will include:

- identifying specific information consumers need to make informed choices about their doctors;

- reviewing the practices of other states relative to the release of information collected by their state medical boards;

- inviting members of the public and interested parties to meet with the committee to engage in a dialogue about these timely issues;

- soliciting opinions from experts in the fields of medicine, law and other professions;

- and finally, recommending regulatory and statutory changes necessary to release to the public useful information on physicians' license application and renewal forms .

The committee is expected to submit its final recommendations to Secretary Douglas by March 31, 1995. Secretary Douglas will then submit the report, along with her recommendations, to the Board of Registration in Medicine. Appropriate administrative changes or legislation will then be filed by the Board of Medicine.

(30)

APPENDIX 2:

Questionnaire developed by the Advisory Committee

Massachusetts Advisory Committee on
Public Disclosure of Physician Information

Questionnaire

_____
Name

_____
Organization

The following is a categorical grouping of information that the Massachusetts Board of Registration in Medicine collects which currently is kept confidential. Please comment on the items of information you believe should or should not be disclosed to the public. Feel free to check the items listed below, and/or provide general comments about each category. Also, feel free to comment on the manner in which such information should be released (e.g., released with comparative norms, doctors' rights to comment prior to release, etc.). Please attach additional pages as needed.

Medical Malpractice	Y	N
• record of medical malpractice claims - pending	_____	_____
• record of medical malpractice claims - settled (no lawsuit)	_____	_____
• record of medical malpractice claims - suits filed	_____	_____
• record of medical malpractice claims - suits settled	_____	_____
• record of medical malpractice claims - suits adjudicated (for claimant)	_____	_____

_____

Comments:

Disciplinary Charges & Actions	**Y**	**N**
• disciplinary charges by governmental entity	_____	_____
• disciplinary charges by hospital, health care/professional group	_____	_____
• disciplinary actions taken by governmental entity	_____	_____
• disciplinary actions taken by hospital, health care/professional group	_____	_____
• called before or warned by state or federal agency re drug privileges	_____	_____

_____

Comments:

Criminal Charges & Convictions	Y	N
• pending criminal charges	_____	_____
• findings short of conviction (e.g., *nolo contendere*, or findings of sufficient facts of guilt without formally entering a guilty finding)	_____	_____
• convictions related to the practice of medicine only	_____	_____
• all convictions (except minor traffic offenses)	_____	_____

_____

Comments:

Medical Education & Post-Graduate Training	Y	N
• accusation of cheating and/or improper conduct during an exam	_____	_____
• disciplinary action at academic institution	_____	_____
• State and National Boards exam scores	_____	_____
• failure on a licensing exam	_____	_____
• non-completion of residency training program	_____	_____
• professional evaluations	_____	_____

_____

Comments:

Employment/Credentialing	Y	N
• withdrawal of application for medical license	_____	_____
• voluntary surrender of medical license	_____	_____
• denial of medical license for any reason	_____	_____
• denial of recertification by specialty boards	_____	_____
• loss of American Specialty Board Certification	_____	_____
• withdrawal of application for hospital privileges or appointment	_____	_____
• resignation from a medical staff in lieu of disciplinary action	_____	_____
• voluntary modification or limitation of scope of practice for reason other than medical condition	_____	_____
• dissolution of professional corporations if related to competence or complaint or allegation re violation of the law	_____	_____
• restrictions on or denial of third party payor participation or enrollment	_____	_____
• reports by peers	_____	_____

Comments:

Physician Health Issues	Y	N
• emotional disturbance, mental illness, organic illness which has impaired ability to practice medicine or function as a medical student (within last 5 years)	_____	_____
• diagnosed with or have medical condition which limits or impairs ability to practice medicine	_____	_____
• use of any chemical substance which in any way interfered with ability to practice medicine (within last 5 years)	_____	_____
• alcohol or other drug dependency (within last 3 years)	_____	_____

Comments:

General Questions

1. Should some form of the following information (which is not now collected) be collected and made available to the public?

   a. Mortality rates for individual physicians, e.g., rates of death per 100 for a particular procedure or surgery?

   b. Complication rates for individual physicians for a particular procedure or surgery?

   If so, should this information, when released, be compared to some accepted norm or risk rate? Other conditions on release?

Comments:

2. Should the Board develop and release a "physician profile" on each licensed physician based on the information it is empowered to collect?

Comments:

APPENDIX 3:

List of those testifying at February 2 public hearing

Speakers at February 2, 1995 Public Hearing held by the Advisory Committee on Public Disclosure of Physician Information

1. Representative Carmen Buell
2. Professor George Annas, J.D., M.P.H.. Boston University School of Public Health, Health Law Department
3. Jack Evjy, M.D., Board of Trustees, **Massachusetts Medical Society**
4. Judith Eaton, M.D., **Physician Health Services**
5. Mark R. Yessian, Ph.D., Regional Inspector General for Evaluation and Inspections, **Office of Inspector General**, U.S. Department of Health and Human Services, Boston, MA
6. Josh Kratka, Staff Attorney, and Deirdre Cummings, Consumer Program Director, **MASSPIRG**, Boston, MA
7. Linda DeBenedictis, President, **New England Patients' Rights Group**, Norwood, MA
8. Elliot M. Stone, Executive Director, **Massachusetts Health Data Consortium**, Waltham, MA
9. Leonard Simon, Esq., **Academy of Trial Lawyers**, Chairman, Malpractice Committee
10. Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Medical School, The Cambridge Hospital (testimony prepared in collaboration with Dr. Sidney M. Wolfe, Director, Public Citizen Health Research Group)
11. David A. Swankin, Esq., President, **Citizen Advocacy Center**, Washington, D.C.
12. Tamara Cubi, **New England Patients' Rights Group**, Norwood, MA
13. Mary Ann McBride, R.N.

APPENDIX 4:

Written testimony received by the Advisory Committee

Written Testimony on Public Disclosure Received by the Advisory Committee on Public Disclosure of Physician Information

Steven V. Angelo, State Representative, Ninth Essex District

Linda DeBenedictis, President, **New England Patients' Rights Group**, Norwood, MA

Leslie E. Kirle, Director, Medical Staff Relations, **Massachusetts Hospital Association**, Burlington, MA

Josh Kratka, Staff Attorney, and Deirdre Cummings, Consumer Program Director, **MASSPIRG**, Boston, MA

Leonard Simon, Esq., **Academy of Trial Lawyers**, Chairman, Malpractice Committee

Elliot M. Stone, Executive Director, **Massachusetts Health Data Consortium**, Waltham, MA

David A. Swankin, Esq., President, **Citizen Advocacy Center**, Washington, D.C.

Steffie Woolhandler, M.D., Associate Professor of Medicine, Harvard Medical School, The Cambridge Hospital (testimony prepared in collaboration with Dr. Sidney M. Wolfe, Director, Public Citizen Health Research Group)

Mark R. Yessian, Ph.D., Regional Inspector General for Evaluation and Inspections, **Office of Inspector General**, U.S. Department of Health and Human Services, Boston, MA

The Commonwealth of Massachusetts
House of Representatives
State House, Boston 02133-1053

STEVEN V. ANGELO
STATE REPRESENTATIVE
NINTH ESSEX DISTRICT
ROOM 473F
TEL. (617) 722-2210

Chairman
Committee on
Natural Resources & Agriculture

February 2, 1995

The Honorable Albert L. Kramer, J.D., Chairman
Advisory Committee on Public Disclosure of
Physician Information
Ten West Street, Third Floor
Boston, MA 02111

Dear Justice Kramer:

I am strongly supportive of the efforts undertaken by the Advisory Committee on Public Disclosure of Physician Information. Public disclosure services are essential to ensuring the health of the many people trusting physicians.

I am especially sensitive to this issue since learning the story of a family in my district. Their daughter died while receiving ongoing medical attention from a physician with an undisclosed history of malpractice complaints. Tragically, this family is only one among many families dealing with the loss of loved ones due to these unfortunate circumstances.

Individuals and families must be better protected from physicians who escape license revocation. As a step towards that end, I have filed legislation creating a public information service within the Board of Registration in Medicine to promote public access to information about physician competence. A central registry would be responsible for maintaining accurate histories of all complaints, suits, out-of-court settlements, court judgements, and disciplinary actions against physicians. All information would be obtained by phoning a toll free number or by submitting a written request to the registry.

Although I expect that this legislation may require revision, I hope that my intent has been clearly communicated and will earn your strong support. The urgency of acting to rectify this crisis cannot be underscored.

Once again, I commend the efforts of the Advisory Committee on Public Disclosure of Physician Information.

Sincerely,

Steven V. Angelo

STEVEN V. ANGELO
State Representative

New England Patients' Rights Group
P. O. Box 141
Norwood, MA 02062-0002

Linda DeBenedictis
President

Phone (617) 769-5720
(617) 769-0882

Commonwealth of Massachusetts
Advisory Committee on Public
Disclosure of Physician Information
Ten West Street
Third Floor
Boston, MA 02111
(617) 727-1788, ext. 354

Dear Members of the Advisory Committee:

I would like to thank the committee for extending a personal invitation for me to testify on behalf of the New England Patients' Rights Group, Inc. on the issue of public disclosure of information regarding physician care. Our goal is to empower consumers to be "included" in the health care system and for our "voices" to be heard. All too often, the interests of the "status quo" have taken precedence over the physical, psychological, emotional, and financial well-being of those they profess to represent.

Victims of medical negligence have no rights or protection. (98 % of "adverse events" stemming from negligence do not lead to malpractice claims and of those that do 2/3 of the cases are won by the physicians.) The cost of treatment due to negligence is absorbed by the health care system not those responsible, who not only profit from the harm but continue to practice on "unsuspecting" patients.

The lack of recognition by the profession and the "system" causes victims to be further abused. Medical negligence traumatizes victims and their families and is responsible for death, physical impairments, chronic pain, post traumatic stress, anxiety disorders, divorce, nervous breakdowns, suicide, difficulty with insurance plans, pre-existing conditions, loss of job, financial problems and on it goes.

Medical negligence and "iatrogenic" injuries are part of a "systematic" problem that is destroying our health care system. But many of us who "voice" our concerns are often patronized, attacked, abandoned, and excluded. We are subjected to cover-ups and a political and legal system that is immune to our pleas for support and empathy. Our trust is violated and innocent lives are destroyed.

In yesterday's Patriot Ledger, Judge Albert Kramer, who chairs this committee, stated that, "There is a balance we have to strike between the public's right to know and a physician's privacy." But we have a double standard because on June 15, 1986, as part of a Spotlight Team investigation, the Boston Globe reported on a service called Physician's Alert based in Chicago that was soon to be in Boston because of the overwhelming demand by physicians. Doctors who subscribe to this network would know if their patients had ever sued anyone - doctor, manufacturer, or neighbor and could refuse to treat based on this search of court records. We, as health care consumers, should have the right to the same information concerning our physicians.

The malpractice system does not prevent malpractice. And doctors do not perform life threatening, unnecessary surgeries, procedures, and tests to protect themselves from "frivolous" litigation. We must recognize that there is a financial incentive that encourages doctors to order risky, invasive procedures as well as a system that "protects" their rights at our expense (physical, emotional, and financial).

Patients must have accurate information about surgeries, tests, and procedures as well as outcome data and it must be tracked by unbiased interests. HMO's who do their own surveys will have a high satisfaction rate; yet when you speak to consumers, as I do, you'll find that many are less than satisfied with their care and treatment. But where and whom do you complain to?

It's deplorable that we have the most expensive health care system in the world, live in what's known as the medical "mecca", have one of the worst medical boards in the country, and then have the audacity to blame victims for negligence. We don't "listen" and our bodies didn't respond to the treatment.

We are subjected to studies that are inconclusive, conflicting, fraudulent, and done without our informed consent. Yet, the profession has only our best interest at heart.

Hospitals, insurance companies, HMO's, the medical board, the medical society, politicians, and the legal system must bear some responsibility for providing consumers with information. They have access to data about physicians and treatment that is not available to the public. We can no longer "trust" what we are told and we no longer know "who" to trust. We must have access to as much information as possible with which to make informed choices.

Our group will complete the questionnaire concerning public disclosure of physician information. In the week since I learned of this meeting, I've included it in our newsletter which some people received yesterday. They will be writing to this committee to "voice" their concerns.

I thank you for listening to some of our issues. In order to address the serious problems concerning "secrecy", our "experiences" need to be shared and we must be "included" in the system. We understand full-well the complexity of the problem. And the New England Patients' Rights Group is committed to educating the public and advocating for patients' rights to accurate, unbiased information.

We will no longer suffer in silence, and we demand that the "truth" be told. I'll be glad to answer any questions.

Sincerely,

Linda DeBenedictis

Linda DeBenedictis
President

Massachusetts Hospital Association

February 2, 1995

Honorable Albert L. Kramer, J.D.
Chairman, Advisory Committee on
Public Disclosure of Physician Information
Ten West Street, Third Floor
Boston, Massachusetts 02111

RE: Public Disclosure of Physician Information

Dear Judge Kramer:

The Massachusetts Hospital Association (MHA) appreciates this opportunity to offer testimony on the issue of public disclosure of physician information. MHA believes that hospitals have a major role to play in providing useful, reliable, and understandable data to the public. We also support the responsible release of health care data by public agencies and recognize the potential value of data as a tool to improve the quality of health care and to help consumers and purchasers make health care decisions. It is extremely, important, however, that any data released be useful to consumers and fair to providers.

Since MHA has been involved in assessing public disclosure of physician-specific information as it relates to the Board of Registration in Medicine's disciplinary requirements, our comments will focus on issues related to that type of disclosure.

MHA supports providing the public with information on disciplinary actions contained in the annual hospital disciplinary action summary submitted to the Board. Recognizing that this would require statutory amendment, we also support the disclosure of the names of individual physicians who have been subject to disciplinary actions in certain cases -- such as the revocation of the privilege to practice medicine at a hospital based on clinical quality or unprofessional behavior. However, before disclosing the names of individual physicians for all categories of disciplinary actions reported to the Board, we believe that existing Board regulations need clarification and definition to promote consistent reporting and to improve the quality of the reported information.

The Board now requires hospitals to report disciplinary actions related to incidents that involve public safety issues, minor infractions, and incidents that may be unrelated to clinical quality or unprofessional behavior. To ensure that the significant actions are reported to the Board and subsequently disclosed to the public, we support a process by which the Board -- in consultation with hospitals, physicians, and others -- would take steps to clarify the reporting requirements.

5 New England Executive Park, Burlington, MA 01803, (617) 272-8000/FAX (617) 272-0466

Further, we believe that public disclosure of any action prior to final disposition may be misleading to consumers and unfair to physicians.

Finally, we believe there is a need for specific guidelines to ensure the accuracy of data released when disclosing physician information to the public. We recommend that the Board establish and implement principles for data release, such as those promulgated by the MHA Board of Trustees (attached), or those adopted by many public and private agencies. One such principle, for example, recommends sharing information with the provider(s) under review prior to public dissemination. This allows an opportunity for corrections and additions of explanatory comments prior to publication.

The format for disclosing information to the public should also be considered. The format should include adjustments to allow for appropriate comparisons among institutions and/or physicians.

Thank you for this opportunity to provide testimony. MHA stands ready to continue to work with the Advisory Committee as it develops its recommendations.

Respectfully,

Leslie E. Kirle

Leslie E. Kirle
Director, Medical Staff Relations

LEK/
attachment

Massachusetts Hospital Association

Statement on Principles of

Collection and Release of Healthcare Quality Data

All organizations, including governmental entities, that intend to develop or disseminate healthcare quality data reports should adhere to the following principles:

1. Although healthcare quality data can be used for several purposes, the prime purpose for healthcare data collection and reporting should be for the improvement of the quality of care delivered. This means the data collected should not only reflect outcomes, but also provide insight into the processes of healthcare delivery.

2. It is not possible, given the current state of the art, to draw valid inferences about the overall quality of care or to initiate quality improvement efforts based on simple global quality measures. Measurement efforts that focus on defined services or aspects of care delivery offer better information for both purchaser decision making and provider quality improvements efforts.

3. Representatives of the target group(s) for data reporting should be meaningfully involved in the development of all aspects of methodology including purposes of data reporting, identification of report topics, collection methods, formatting, and methods and means for release and dissemination.

4. The entire methodology for collecting and analyzing the data should be disclosed to all relevant organizations and individual providers.

5. Data collection and analytical methodologies should be used that meet accepted standards of validity and reliability.

6. The limitations of the data sources and analytic methodologies used to develop reports should be clearly identified and acknowledged, as well the appropriate and inappropriate uses of the data.

7. To the greatest extent possible, comparative healthcare data initiatives should use standards-based norms derived from widely accepted practice guidelines.

8. Whenever possible, data regarding the entire episode of care under study should be collected.

9. Provider profiles and any other information that is compiled regarding provider performance should be shared with the provider(s) under review prior to public dissemination. An opportunity for corrections and additions of explanatory comments should be provided prior to publication. The profiles should include only data that reflects care under control of the provider for whom the profile is prepared.

10. Comparisons among provider profiles should adjust for case mix, intensity, and other relevant factors, and should distinguish between the ordering or referring provider and the provider supplying the service or procedure.

11. Effective safeguards to protect against the unauthorized use or disclosure of healthcare data, especially comparative data, should be developed and implemented.

12. Effective safeguards to protect against the dissemination of inconsistent, incomplete, invalid, inaccurate, or subjective data should be developed and implemented.

13. The quality and accuracy of provider profiles, data sources, and methodologies should be evaluated regularly.

14. Providers should be reimbursed for the reasonable costs that are required for assembling, formatting, and transmitting data and information to organizations that develop or disseminate healthcare data.

15. The benefits of healthcare data collection and reporting should outweigh the costs of developing and disseminating the reports.

MASSPIRG
Massachusetts Public Interest Research Group
29 Temple Place, Boston, MA 02111-1305 (617) 292-4800

February 2, 1995

TESTIMONY OF MASSPIRG ON DISCLOSURE OF PHYSICIAN INFORMATION BY THE BOARD OF REGISTRATION IN MEDICINE

Submitted to: Massachusetts Advisory Committee on Public Disclosure of Physician Information
Submitted by: Josh Kratka, MASSPIRG Staff Attorney
Deirdre Cummings, MASSPIRG Consumer Program Director

Thank you for inviting us to testify today on behalf of the Massachusetts Public Interest Research Group (MASSPIRG), the state's largest consumer protection organization. MASSPIRG has advocated for the rights of health care consumers on issues relating to the Board of Registration in Medicine for nearly ten years.

The creation of this Advisory Committee by Consumer Affairs Secretary Priscilla Douglas and the decision of the Massachusetts Medical Society to file legislation providing comprehensive disclosure of physician information have combined to open a unique window of opportunity for health care consumers. For the first time, consumers appear to be on the brink of gaining ready access to objective information relating to physician competence and quality of care. Individual physician profiles are the centerpiece of what could be a revolutionary advance.

We use the word "revolutionary" advisedly. The cancer patient deciding who should perform his surgery, the pregnant woman uncertain whether to have her baby delivered at the local hospital, and the family new to Massachusetts looking for a pediatrician currently have far less relevant and reliable information than a homeowner shopping, Consumer Reports in hand, for a lawnmower or a VCR. Health care consumers rely on word of mouth, personal anecdotes or, most typically, sheer random chance in making these crucial decisions.

But imagine being able to study objective, comprehensive and understandable profiles of recommended surgeons or pediatricians, or a chart comparing caesarean-section rates and delivery outcomes at local hospitals. Access to this kind of information -- whether mailed out the old-fashioned way from the Board of Registration in Medicine or accessed directly through a personal computer or a terminal in a public library -- will educate and empower consumers, allowing them to make more intelligent choices among providers and to ask pertinent

questions of the providers they do choose. This, in turn, will create a level playing field where, for perhaps the first time in the health care field, competitive pressures will be exerted by physician competence and quality of care. Such an advance would instantly become a model for policymakers at both the state and federal levels.

For these reasons -- the inherent power of the information to be disclosed, and the groundbreaking nature of this enterprise -- care must be taken to do the job right.

PHYSICIAN PROFILES

Physician profiles must provide information that is (1) meaningful for consumers and (2) fair to physicians. There is no conflict whatsoever between these goals.

To be "meaningful," information must be relevant to a consumer's choice of physician, and be presented in a format that can be understood by the lay person.

The following considerations should be taken into account in determining what is "meaningful":

1. Not all information collected by the Board need be disclosed on the profile; to avoid information overload, only the most significant elements of a physician's record should be routinely included (additional information should remain a matter of public record accessible through other means).

2. All information should be presented in proper context. Thus, for example, malpractice claims information for an individual physician should include a comparison with data for a typical practitioner in that specialty; test scores (if relevant) should by accompanied by an explanation of the grading scale and the purpose of the test.

3. Information should be as objective and fact-based as possible. We reject, for example, the Mass. Medical Society position that malpractice information should exclude actual numbers of claims or judgments, in favor of a characterization such as "above average." If information is presented properly, consumers are capable of making their own comparisons and drawing their own conclusions.

To be "fair," profile information must have all of the above attributes and one more: it must be complete. Without full reporting and collection of data, some doctors and hospitals will look better than others simply because negative information has not been reported.

We must stress, however, that the development and release

of profiles must not be held hostage to data reporting problems. The Board and other interested groups must make every effort to improve data collection even as it begins the task of developing the profiles. Presumably, the onset of physician profiling, to be implemented at a date certain, will encourage the physician community to throw its own weight behind efforts to achieve full reporting.

We suggest the following format for profiles:

A listing of basic biographical information: age, schooling, credentials, years in practice, areas of specialty, hospital affiliation, etc.

Description of current license status and any current restrictions on practice, hospital privileges, insurance reimbursement, etc.

Disclosure of testing facilities, labs, etc., in which the physician has a financial interest.

Side-by-side comparison of physician's malpractice and disciplinary history with that of typical practitioner in that specialty.

Relevant criminal history.

MORTALITY AND COMPLICATION RATES

Mortality and complication rates by procedure and physician, should be collected and made available to the public. Equally or even more important, rates for hospitals and other relevant provider units should be compiled and disseminated. In both cases, this information should be accompanied by relevant comparisons to state and national rates. It should also include explanatory information that (1) would allow a lay person to make sense of the numbers and (2) adequately describes any limitations of this type of statistical data. For example, there may need to be allowances made for differing patient populations or other potentially mitigating or confounding factors.

HANDLING OF SPECIFIC TYPES OF PHYSICIAN INFORMATION

The following comments are taken directly from MASSPIRG's response to the Advisory Committee's questionnaire. We have made an effort to identify whether information should be (a) disclosed on physician profiles, (b) not routinely included on profiles but made available to the public, or (c) kept confidential by the Board.

Medical Malpractice

Medical malpractice claims information should absolutely be a

matter of public record and included in physician profiles. On a profile, information as to numbers of suits filed, settled and adjudicated needs to be provided to consumers in a context of comparative norms for each specialty. Thus, one or two claims over a number of years of practice may or may not appear to be a cause for concern; if, as physicians often claim, everyone gets sued, this will quickly become apparent to consumers and will not be unduly prejudicial (unless the number of claims is unusually high).

Our understanding is that the Board does not have complete information regarding the listed actions, due either to incomplete reporting or internal database problems or both. These problems need to be identified and addressed.

NOTE: We are not clear as to what malpractice "claims" without lawsuits refer to, and thus take no position as to whether they should be disclosed.

Disciplinary Charges & Actions

Disciplinary charges by a government entity, hospital, or healthcare/professional group should only be disclosed to the public once they surpass a given threshold number, since these are not final adjudications. Three or more charges, for example, even if not resulting in disciplinary action, may indicate a problem.

Disciplinary actions taken would obviously be an essential component of physician profile information.

Again, the Board needs to enforce full and complete reporting by all hospitals in order to ensure a fair and objective database.

Criminal Charges & Convictions

Any criminal conviction, or finding short of conviction, that is related in any way to the physician's ability and reliability regarding the practice of medicine should be disclosed, probably on his or her profile. Sexual crimes, for example, might constitute a "practice-related" offense. In addition, convictions of any capital crimes should be disclosed.

Medical Education & Post-Graduate Training

Disciplinary action taken by an academic institution should only be available for a limited number of years only, perhaps for the first five years of practice.

In general, the information in this category (with the exception of professional evaluations) should be publicly available but not necessarily disclosed on a profile.

Professional evaluations probably contain among the most

important and reliable information available about physician competence. We do, however, understand the need to encourage full and honest evaluations, and this goal is served by keeping evaluations confidential. And ideally, poor evaluations would ultimately result in publicly disclosable disciplinary action. We are thus undecided as to whether professional evaluations should be publicly available or should remain confidential. In any case, they must be reported to the Board and open to the Board's Disciplinary Unit.

Employment/Credentialing

For peer review reports, see previous comment on professional evaluations.

In general, the information in this category (with exceptions as marked on questionnaire) should be publicly available. It should also be included on a physician's profile if it relates to any curtailment, modification or other effect on the physician's practice, or if the physician is still practicing in a specialty in which his or her license or certification has been denied within a given number of years.

Physician Health Issues

Disclosure of health information should clearly explain the impact of the impairment on the physician's practice, both to warn consumers of any improper or illegal practice of medicine and to avoid unfair discrimination against an otherwise competent and qualified physician who suffers from some disability. Any condition that results in a restriction of practice must be noted on a physician's profile.

As to drug or alcohol problems, as long as the physician has voluntarily enrolled in and is in full compliance with the terms of a Board-approved treatment and monitoring program, this information should only be disclosed to the public for one year. If the physician has not voluntarily enrolled in or has violated the terms of his or her treatment program, this information should be fully disclosed on the physician profile.

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February 2, 1995

The Honorable Albert L. Kramer, J.D.
Chairman, Advisory Committee on Public Disclosure
of Physician Information
Ten West Street
Boston, MA 02111

Re: Public Disclosure of Information
Medical Peer Review

Dear Judge Kramer:

I appreciate the opportunity to be heard today by the Advisory Committee on Public Disclosure of Information. I also want to express appreciation on behalf of the Massachusetts Academy of Trial Attorneys, for whom I chair the Medical Malpractice Committee.

There is a need to remedy a significant problem which exists in regard to discovery of information in the course of a civil liability suit where a patient has died or been injured during a hospitalization. Current law, G.L.M. Ch. 111, Sec. 203 to 205, acts to drop a veil of secrecy around disastrous events which may occur in the course of a hospitalization. If there is any written record of review of the incident it disappears under the cover of "peer review." This, in effect, shields those responsible for a tragedy from providing an accurate accounting of the events which led up to and caused the disaster. The purpose of House No. 5216, filed last year by the Massachusetts Academy of Trial Attorneys, was intended to remedy that problem and to provide the patient or his family with equal access to the facts and to the truth. This is entirely appropriate when a patient has been injured or killed in an untoward event occurring in a hospital setting.

At the same time the proposed legislation contained specific and direct language to protect confidential opinions of physicians or others involved in the peer review process where the objective is improvement in the quality of care within hospitals. In that way, the positive purposes of privilege and protection in the original peer review statute are preserved. Also, there are provisions in House Bill No. 5216 which provide that certain documents can only

be obtained upon showing that there is a "substantial need for that information and whether that party is unable without undue hardship to obtain the substantial equivalent of the information through other means."

There are multiple safeguards available to protect confidentiality of true peer review opinions in the proposed bill as well as in existing legislation. As additional protection which would be afforded to peer reviewers, I am enclosing an article entitled, "Discovering Psychological Records in Personal Injury Cases," which describes the "in camera" procedure which now exists for reviewing psychological records. I would anticipate a similar process and protection would be in effect for true peer review opinions. As you will note, there are multiple and effective safeguards built into this system which would insure confidentiality and continue to allow effective quality reviews. In fact, I have fears that if the peer review process is not subject to some appropriate monitoring, and independent review it could easily evolve into a system so secretive that it would become a shield for cover-ups.

There has been a objection to H. 5216 raised by Attorney Michael Kelly on behalf of the Massachusetts Medical Society in regard to H. 5216 which should be addressed. Mr. Kelly has asserted that under Chapter 111, section 204(b), incident reports or other records are available and not immune from subpoena or discovery and he quoted the existing statute in support of that position. Mr. Kelly, I understand, is not a practicing trial attorney and does not deal with the interpretation of the relevant statute in the Massachusetts Trial Court system. With due respect, Mr. Kelly is in error. Incident reports are NOT discoverable if they fall within the very broadly defined "peer review process" I might agree with Mr. Kelly that the legislative *intent* of Section 204(b) of Chapter 111 was to have incident reports discoverable, notwithstanding that they may have been given to a peer review committee. However, that is not how it has worked in practice. The very same incident report, even though not the <u>product</u> of either a peer review committee or a patient care assessment committee, must be kept from discovery if it is also required to be maintained by the Board of Registration. It remains a secret document merely because the hospital's patient care assessment coordinator has designated it as a record of a "peer review committee".

I am enclosing a legal brief which was prepared by a defendant in support of a motion to prevent discovery of an incident report in a medical malpractice case. I represented the plaintiff in that

case. Although the brief is technical, the essence of the argument, with which the court agreed, is that if an incident report has been presented to a peer review committee OR a "patient care assessment committee" the incident report (or document) is NOT discoverable. In this particular case a Superior Court judge refused to order the New England Baptist Hospital to turn over the incident report based on the argument that the document had been presented to the patient care assessment committee. (Please see the last paragraph on page 6 of the enclosed brief.) Under those circumstances the court found that secrecy prevails. In essence, a new black hole for otherwise discoverable information was created by the existing legislation. That is why it needs to be fixed. The proposed legislation, H. 5216, would have allowed discovery of facts which ought to come to light and be discoverable, while maintaining the privilege which is essential to legitimate peer review function. Indeed, H. 5216, as drafted, did not give immediate access to a party seeking the documents, it only provided a mechanism for a judge to look at the documents, in camera, and make an appropriate determination. Even then, there would be safeguards in place to prevent improper or unauthorized use of any information which might be contained in those documents.

I realize that all of this is somewhat technical, however, the existing law badly needs to be modified to accomplish its true objectives and provide openness and fairness to patients and the public at large. After all, they are the ones the law is intended to protect and benefit.

Once again, thanks for the opportunity to be heard by the Advisory Committee on Public Disclosure of Physician Information.

I have taken the liberty of attaching documents referred to in this letter and my oral testimony.

Sincerely,

Leonard A. Simon
Chair, Medical Malpractice Committee
Massachusetts Academy of Trial Attorneys

LAS/dmt
Enclosures:

1. House Bill No. 5216 (1994, supported by MATA)
2. Memorandum in Support of the Opposition of the Defendants to Compel Production of Documents by the Hospital to Plaintiff's Second Request for Documents, and Cross-Motion for a Protective Order
3. *Errors in Medicine,* Journal of the American Medical Association, December 1994
4. Final Proof of an op-ed piece to appear in the next issue of Physician's News, by Leonard A. Simon
5. *Discovering Psychological Records in Personal Injury Cases,* Cheri L. Crow, Esq., Civil Litigation Section News 1993

HOUSE . . . . . No. 5216

By Mr. DiMasi of Boston, petition of Salvatore F. DiMasi for legislation to provide for judicial determinations concerning medical peer review committees. Health Care.

The Commonwealth of Massachusetts

In the Year One Thousand Nine Hundred and Ninety-Four.

AN ACT TO PROVIDE FOR JUDICIAL DETERMINATIONS OF CERTAIN PRIVILEGES.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 1 of chapter 111 of the General Laws, as most recently amended by chapters 309 and 415 of the acts of 1993, is hereby further amended by adding, in line __, the following three sentences: — In order for a meeting or proceeding to be considered that of a "medical peer review committee," the following criteria shall be satisfied:

1) a meeting of two or more persons shall be held pursuant to the written by-laws referred to in the preceding paragraph; and

2) for each such meeting, contemporaneous minutes of the meeting or proceeding must be prepared, which shall include a list of documents received, a summary of oral and written testimony given, the identify of each person in attendance, the identity of each person giving testimony and the result of the committee's deliberations, including but not limited to all actions recommended and/or taken by the committee as a result of such meeting. No privilege or right of confidentiality shall apply unless each of the criteria referred to in clauses (1) and (2) is satisfied. If a dispute arises as to whether a "medical peer review committee" has been convened within the meaning of this section, a determination shall be made by submitting the applicable by-laws and contemporaneous minutes of the meeting or proceeding in camera to a judge having appropriate jurisdiction, in accordance with the procedures set forth in subsection (f) of section 204.

SECTION 2. Section 204 of said chapter 111, as appearing in the 1992 Official Edition, is hereby amended by adding the following two subsections: —

(f) Any person claiming confidentiality of proceedings, records or reports under this section shall have the burden of proving by clear and convincing evidence that such proceedings, records or reports are those of a medical peer review committee. Upon motion of any party, the court in which any civil action is pending shall hold a hearing to make this determination. The person or entity claiming confidentiality pursuant to this section shall submit to the court, for an in camera inspection, a complete copy of all documents at issue and minutes of all proceedings at issue.

Further, if the court determines that such proceedings, records or reports are those of a medical peer review committee, the court shall then determine whether the party seeking disclosure has a substantial need for the information and whether that party is unable without undue hardship to obtain the substantial equivalent of the information through other means; upon making such determination, the court shall order disclosure.

(g) The court may order that underlying factual information and documentation shall be discoverable but that the opinions rendered by persons testifying at the medical peer review committee and the conclusions of the medical peer review committee shall not be discoverable. In no event shall the ultimate conclusions of a medical peer review committee as to whether or not a medical provider departed from the standard of care be admissible in a civil action for medical malpractice.

Filed, Dec 15, 93

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT
CIVIL ACTION NO.: 92-0297-I

KEVIN E. KELLY,
Plaintiff,

v.

DANIEL P. CROWLEY, R.N. AND NEW ENGLAND BAPTIST HOSPITAL,
Defendants.

OPPOSITION OF THE DEFENDANTS TO PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DOCUMENTS BY THE HOSPITAL TO PLAINTIFF'S SECOND REQUEST FOR DOCUMENTS, AND CROSS-MOTION FOR A PROTECTIVE ORDER

The defendants, Daniel P. Crowley, R.N. and New England Baptist Hospital ("defendants"), hereby oppose the plaintiff's Motion to Compel Production of Documents By New England Baptist Hospital to Plaintiff's Second Request for Production of Documents on the grounds that the Hospital Incident Report sought by the plaintiff constitutes "peer review" and, as such is protected from discovery pursuant to M.G.L. c. 111, §§ 203, 204 and 205 and the corresponding regulations of the Board of Registration in Medicine, 243 CMR 3.00, et seq.

In addition, the defendants move for a protective order pursuant to Rule 26(c) of the Massachusetts Rules of Civil Procedure providing as follows:

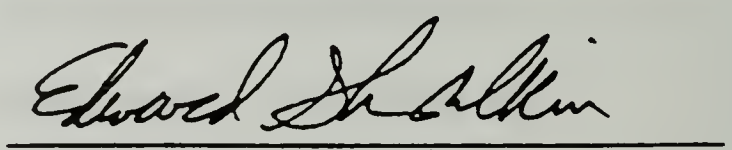
1. The identities of all persons who were interviewed or furnished information relating to the care rendered to the plaintiff to any peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee, and any representative thereof, shall remain confidential and immune from discovery;

2. The contents of all records and reports, including an internal incident report, relating to the plaintiff which were generated to comply with the defendant's risk management and/or quality assurance programs and which were necessary to the work-product of a medical peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee shall remain confidential and immune from discovery; and

3. All deliberations, opinions, conclusions and actions taken by a medical peer review committee affiliated with New England Baptist Hospital, including the Patient Care Assessment Committee and any representative thereof, relating to the plaintiff shall remain confidential and immune from discovery.

WHEREFORE, the defendants respectfully request that this Court deny in its entirety the plaintiff's Motion to Compel Production of Documents by New England Baptist Hospital to Plaintiff's Second Request For Production of Documents, and that this Court allow the defendants' Cross-Motion for a Protective Order.

The Defendant,
NEW ENGLAND BAPTIST HOSPITAL and
DANIEL P. CROWLEY, R.N.,
By their Attorneys,



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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

SUPERIOR COURT DEPARTMENT
OF THE TRIAL COURT
CIVIL ACTION NO.: 92-0297-I

KEVIN E. KELLY,
Plaintiff,

v.

DANIEL P. CROWLEY, R.N. AND NEW ENGLAND BAPTIST HOSPITAL,
Defendants.

MEMORANDUM IN SUPPORT OF THE OPPOSITION OF THE DEFENDANTS TO PLAINTIFF'S MOTION TO COMPEL PRODUCTION OF DOCUMENTS BY THE HOSPITAL TO PLAINTIFF'S SECOND REQUEST FOR DOCUMENTS, AND CROSS-MOTION FOR A PROTECTIVE ORDER

INTRODUCTION

The defendants, Daniel Crowley, R.N. ("Nurse Crowley") and New England Baptist Hospital ("Hospital"), submit the following Memorandum in Support of their Opposition to the Plaintiff's Motion to Compel Production of Documents By New England Baptist Hospital to Plaintiff's Second Request for Production of Documents on the grounds that the Hospital Incident Report sought, by the plaintiff constitutes "peer review" and, as such, is protected from discovery pursuant to M.G.L. c. 111, §§ 203, 204 and 205 and the corresponding regulations of the Board of Registration in Medicine, 243 CMR 3.00, et seq.

This Memorandum is also submitted in support of the defendants' Cross-Motion for a Protective Order pursuant to Rule 26(c) of the Massachusetts Rules of Civil Procedure under which the following order is sought:

1. The identities of all persons who were interviewed or furnished information relating to the care rendered to the plaintiff to any peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee, and any representative thereof, shall remain confidential and immune from discovery;

2. The contents of all records and reports, including an internal incident report, relating to the plaintiff which were generated to comply with the defendant's risk management and/or quality assurance programs and which were necessary to the work-product of a medical peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee shall remain confidential and immune from discovery; and

3. All deliberations, opinions, conclusions and actions taken by a medical peer review committee affiliated with New England Baptist Hospital, including the Patient Care Assessment Committee and any representative thereof, relating to the plaintiff shall remain confidential and immune from discovery.

FACTUAL AND PROCEDURAL SUMMARY

The plaintiff in this case was admitted to New England Baptist Hospital in June, 1989 for back surgery. During his recuperation at the Hospital following surgery, the plaintiff developed a case of intractable hiccups. In accordance with physician's orders, defendant Nurse Daniel Crowley administered Thorazine to the plaintiff on June 18, 1989 to relieve the hiccups. According to the plaintiff, the Thorazine injection caused a hematoma and sterile abscess to develop on the plaintiff's right arm, the site of the injection. The plaintiff alleges that Nurse Crowley was negligent for selecting the plaintiff's arm as an injection

site for Thorazine, and that New England Baptist Hospital is vicariously liable for the acts of Nurse Crowley, its employee.

In December, 1992, the plaintiff propounded a Second Request for Production of Documents to the Hospital seeking, among other things, the production of all incident reports relating to the plaintiff. A Hospital Incident Report had previously been identified by the Hospital in response to discovery propounded by the plaintiff.

As discussed in greater detail below as well as in the attached Affidavits and portions of the Hospital's Patient Care Assessment Program, the Incident Report was generated in conformity with the Hospital's quality assurance and risk management programs. It was sent to the Hospital's Patient Care Assessment Committee (a medical peer review committee), and was used by the Committee, through its Patient Care Assessment Coordinator and its agents, as an integral part of its investigation of Hospital procedures and, more specifically, the quality of health care provided to the plaintiff.

Accordingly, the Hospital objected to the plaintiff's request for the Incident Report on the grounds that the report constitutes confidential "peer review." To this end, the defendant cited in its Rule 34 Response the operative statutes and the corresponding regulations of the Board of Registration

in Medicine which confer the privilege of confidentiality upon the Incident Report.[1]

The plaintiff has now moved for the production of the Incident Report in response to which the defendants have submitted an Opposition and Cross-Motion for a Protective Order pursuant to Rule 26(c) of the Massachusetts Rules of Civil Procedure.

ARGUMENT

I. M.G.L. c. 111, §§203, 204 AND 205, AND THE CORRESPONDING REGULATIONS OF THE BOARD OF REGISTRATION IN MEDICINE, PROHIBIT THE DISCLOSURE OF THE HOSPITAL INCIDENT REPORT.

Generally, M.G.L. c. 111, §§ 203, 204 and 205, together with the concomitant regulations of the Board of Registration in Medicine, were intended "to assist the physicians and health care institutions of the Commonwealth in their efforts to identify problems in practice before they occur and to put in place preventive measures designed to minimize or eliminate substandard practice." 243 CMR 3.01, Regulations of the Board of Registration in Medicine, a copy of which is attached as Exhibit "D."

To promote the improvement of medical care and procedures through self-analysis, the Legislature enacted M.G.L. c. 111, §204, which conferred a broad privilege of confidentiality on those persons and institutions who participate in the "peer

---

[1] The defendant also objected to the production of the Incident Report on attorney-client privilege and work-product grounds. Peer Review, however, is the primary basis for preserving the confidentiality of the Incident Report, and the other two objections are, therefore, waived with respect to the disputed Request.

review" process. St. 1986, c. 351. Among other things, §204 provides that:

> reports and records of a medical peer review committee shall be confidential and shall not be subject to subpoena or discovery, or introduced in to evidence, in any judicial or administrative proceeding, except proceedings held by the board of registration in medicine, social work or psychology.

M.G.L. c. 111, §204(a) (emphasis supplied). The statute further provides that those persons attending a meeting of any such peer review committee shall not be required nor allowed to testify about the peer review committee proceedings. See also Beth Israel Hospital v. Board of Registration in Medicine, 401 Mass. 172, 174 (1987).

Recognizing that quality assurance and risk management programs play a vital role in improving the quality of patient care, and that such programs augment the effectiveness of the peer review process, the Legislature subsequently enacted M.G.L. c. 111, §205. St. 1987, c. 579, approved December 16, 1987. By enacting §205, the Legislature expanded considerably the already broad privilege against disclosure created under §204(a). Whereas §204 established a privilege over the "proceedings, reports or records" of a peer review committee, §205 expanded that privilege to protect the "[i]nformation and records which are necessary to comply with risk management and quality assurance programs and which are necessary to the work product of medical peer review committees." M.G.L. c. 111, §205(b).

As the agency charged with the enforcement of these statutes, the Board of Registration in Medicine promulgated a series of regulations designed to interpret and implement this legislative expression. Not only did these regulations expound upon the privilege of confidentiality over the peer review process, but they also mandated that health care institutions, such as the defendant Hospital, establish internal review and reporting procedures through their quality assurance and risk management programs. The regulations also reaffirmed the confidential nature of such materials, including internal incident reports:

> To assure free self-examination by physicians and institutions, the Legislature provided extensive safeguards of <u>confidentiality, immunity and privilege for both internal reviews and reports to the Board.</u> It is the explicit intent of 243 CMR 3.00 that such safeguards be strengthened and extended to the extent permitted by law.

243 CMR 3.01. Exhibit "D."

Contrary to the plaintiff's arguments, the Hospital Incident Report epitomizes the type of document which these statutes and regulations were designed to protect. The report was sent to and used by the Hospital's Patient Care Assessment Committee during its review of the care rendered to the plaintiff, and formed a basis for the conclusions reached by those responsible for implementing the Hospital's quality assurance, risk management and peer review activities. As such, it is privileged.

To trigger the privilege conferred by §204, §205(b) requires that the incident report:

> (i) be a record which is necessary to comply with risk management and quality assurance programs established by the Board of Registration in Medicine; and
>
> (ii) be necessary to the work product of the Hospital's Medical Peer Review Committee.

The risk management and quality assurance programs to which §205 refers are set forth in 243 CMR 3.00 et seq. Specifically, 243 CMR 3.02 defines a "medical peer review committee" as including "groups responsible for efforts usually designated as Quality Assurance, Utilization Review, Risk Management and Credentialing." More to the point for this case, the same regulation defines a hospital's "Patient Care Assessment Committee" as a type of "medical peer review committee." See Exhibit "D."

Following the promulgation of these regulations, the Hospital instituted a Patient Care Assessment Program incorporating both the duties and authority contemplated by these regulations ("the Program"). Attached as Exhibit "C" is a copy of the relevant portions of the Hospital's Patient Care Assessment Program. This Program was in effect at the time the plaintiff underwent the subject treatment at the Hospital, and at the time the Hospital Incident Report was prepared.[2] As stated on Page 1 of the Program, its "Purpose" is as follows:

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[2] Because of its sheer bulk, the entire Program is not attached. Should the Court wish to review any or all of the remaining sections of the Program described in the Table of Contents, the defendant will produce them immediately.

> In keeping with the intent of Chapter 351 of the Acts and Resolves of 1986 (the Medical Malpractice Tort Reform Act), New England Baptist Hospital has established a Patient Care Assessment Program. The program consists of activities in risk identification and analysis, loss prevention and risk reduction, and patient communication and documentation. In conjunction with the Hospital's existing quality assurance and other risk reduction activities, this program will help achieve the Hospital's goal of providing optimal, achievable health care in a cost effective and safe environment.

Exhibit "C", at 1. Virtually every element of the Program was designed to comply with and correspond to the statutory and regulatory framework governing the quality assurance, risk management and peer review programs required in Massachusetts.

For example, 243 CMR 3.07(3)(a)-(d) requires that the Hospital establish a "Required Internal Incident" reporting system.[3] As Exhibits "A," "B" and "C" demonstrate, the Hospital complied with these regulations. Pages 4 and 5 of the Program describe the responsibilities of the Patient Care Assessment Committee of the Hospital (PCAC). Among the PCAC's responsibilities are the oversight and implementation of all

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[3] The "Required Internal Incident Reporting System" required by 243 CMR 3.07 and instituted under the Hospital's Program must be distinguished from the "Major Incident Reporting to Board of Registration in Medicine" set forth under 243 CMR 3.08. The latter type of incident report is prepared following a "major incident" such as the death or "major or permanent impairment" of a patient. Unlike Internal Incident Reports, Major Incidents must be reported to the Board of Registration in Medicine. The Hospital Incident Report concerning the plaintiff was an Internal Incident Report and, therefore, is subject to the requirements of 243 CMR 3.07. The difference is important because the plaintiff attempts, in an apparent misunderstanding of the regulations, on pages 6 and 7 of his supporting Memorandum to apply certain of the regulations in §3.08 (governing Major Incident Reports) to the Hospital's §3.07 Internal Incident Report.

aspects of the Hospital's Patient Care Assessment Program, including the "investigation and analysis of incident reports." Id. at 4, ¶'s 1 and 3. Pages 10 through 12 of the Program are devoted exclusively to "Incident Reporting" at the Hospital. A comparison of the relevant provisions of the Program to the provisions of 243 CMR 3.07(3)(a)-(d) demonstrates that the Hospital's internal incident reporting system conformed to the regulations.

The Hospital's Incident Report concerning the plaintiff, in turn, was generated pursuant to the Hospital's Program, in accordance with these regulations. As the Affidavits of Loretta Joy, R.N., M.S.N., and Gary Reed indicate, the Report was received by Ms. Joy and forwarded to Gary Reed, then the Hospital's Patient Care Assessment Coordinator. See Exhibits "A" and "B." Upon receiving and reviewing the Incident Report, it was decided that further evaluation of the case was warranted. Records were reviewed and various Hospital personnel were interviewed. Following its conclusion, opinions were formed and recommendations were made as to the quality of the health care provided to the plaintiff and the circumstances under which the incident occurred. See Exhibit "A" at 4 and "B" generally. This is peer review.

Under the statutory reference, the Hospital Incident Report is immune from discovery because it satisfies the criteria of M.G.L. c. 111, §205. First, since the Incident Report was "necessary to comply" with the Hospital's Patient Care Assessment Program, a quality assurance and risk management program specifically established to meet the

requirements of M.G.L. c. 111, §§203, 204 and 205, the first of §205's criteria is satisfied.

Second, as the Affidavits of Loretta Joy and Gary Reed demonstrate, the Incident Report was necessary to the work product of the Patient Care Assessment Committee, which is itself a "medical peer review committee" within the meaning of the regulations. See generally the Affidavit of Loretta Joy, and Affidavit of Gary Reed, attached as Exhibits "A" and "B" respectively. The Incident Report enabled the Committee to fulfill its legal duties of "evaluation and improvement of the quality of health care..." and to determine "whether health care services were performed in compliance with the applicable standards of care...." 243 CMR 3.02. Having satisfied the two-tier test of M.G.L. c. 111, §205, the Hospital Incident Report is immune from discovery under M.G.L. c. 111, §204, and the plaintiff's motion should be denied.

II. NONE OF THE ARGUMENTS ADVANCED BY THE PLAINTIFF SUPPORT THE DISCLOSURE OF THE HOSPITAL INCIDENT REPORT.

The plaintiff's Memorandum in Support of his Motion to Compel raises a host of arguments challenging the confidentiality of the Hospital Incident Report. First, on page 4 of his Memorandum, the plaintiff argues that the Hospital is "merely seeking to conceal a discoverable document...by 'labeling' it with a different title and improperly characterizing the nature of the document."

Contrary to this unsupported argument, the Hospital has not conveniently labeled the document simply to protect it.

The Incident Report was prepared because 243 CMR 3.07 and the Hospital's Patient Care Assessment Program mandate it. 243 CMR 3.07(3)(j) delineates the specific categories of information that must be included in a Required Internal Incident Report.

Next, the plaintiff's reliance on the statutory exception to the peer review privilege found in M.G.L. c. 111, §204(b) is misplaced. It is undisputed that the "raw materials" relied on by a medical peer review committee are not privileged if they are "obtained from other sources." Beth Israel Hospital Association v. Board of Registration in Medicine, 401 Mass. 172, 183 (1987). The plaintiff, however, urges the Court to focus on a few select words found in §204(b) while ignoring the rest of the sentence he quotes from the statute. On page 4 of his Memorandum, the plaintiff argues that §204(b) "explicitly" provides that incident reports are discoverable and, therefore, the disputed document cannot be peer review precisely because it is an incident report. This interpretation ignores the second half of the quoted sentence. What §204(b) actually states is that incident reports are not automatically protected from discovery "merely because they were presented to such committee in connection with its proceedings." M.G.L. c. 111, §204(b). By disregarding this qualifying language, the plaintiff is seeking to have the exception to the privilege swallow the privilege. In Beth Israel, the Supreme Judicial Court rejected similar attempts to limit the scope of the peer review privilege, stating in part:

> It does not seem reasonable that the Legislature would create a [medical peer review committee] privilege and through an exception undercut the confidentiality that that privilege allows. If the privilege was designed to do anything, it was designed to foster aggressive critiquing of medical care by the provider's peers. An exception as broad as the board envisages frustrates this goal.

Beth Israel, supra, 401 Mass. at 182.

Perhaps the most glaring deficiency in the plaintiff's Memorandum is its complete disregard of M.G.L. c. 111, §205. Approved December, 1987, (after the Supreme Judicial Court's decision in Beth Israel, supra), §205 expanded significantly the privilege created under §204. If any question ever existed whether the Hospital's Incident Report was discoverable under §204, that question is clearly resolved by a review of §205. See Argument, infra, at I. Nowhere in the plaintiff's Memorandum is §205 even cited, much less distinguished.

The plaintiff's next argument, that hospital incident reports have been held discoverable in Massachusetts, is also inapposite. The plaintiff cites Shortwell v. Winthrop Community Hospital, 26 Mass. App. Ct. 1014 (1988) in support of his contention. Conspicuously absent from his discussion of this case is the fact that the incident reported there involved an injury caused by an electric sliding door. Unlike this case, the Shortwell incident and incident report had nothing to do with peer review, or the provision of medical care by the hospital. Nowhere are the peer review statutes, regulations or cases even mentioned.

Although no reported cases could be found, the available Massachusetts decisions in the Superior Court demonstrate that the Courts have not intruded on the confidentiality afforded peer review. See Cuccinello v. Healey, Middlesex Superior Court, civil action no. 89-5534-B ("§205 extends the protection offered by §204 to incident reports required to be furnished to the Board of Registration in Medicine as well as those used by a peer review committee"); Cragan v. Weinberg, Suffolk Superior Court, civil action no. 92-2728-B (Hospital incident report and other materials deemed confidential); Hughes v. American Regent Laboratories, U.S.D.C. for District of Massachusetts, civil action no. 92-11950. These decisions are collectively attached as Exhibit "E."

Finally, on pages 6 and 7 of his Memorandum, the plaintiff argues that the Hospital Incident Report should be disclosed because, according to the plaintiff, the Hospital has failed to demonstrate it is privileged under 243 CMR 3.00 et seq. Although the plaintiff's interpretation of the regulatory requirements is somewhat imprecise in this area, the attached Affidavits of Loretta Joy and Gary Reed, and the Patient Care Assessment Program, as well as the discussion infra, establish the confidentiality of the Incident Report under the applicable statutes and regulations.[4]

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[4] One of the purported requirements advanced by the plaintiff, which appears to be cited twice on these pages, does not apply. This was an internal incident report, not a Category II incident requiring a Major Incident Report. Accordingly, the Hospital was not required to file it with the Board of Registration.

In short, the plaintiff's arguments do not warrant the disclosure of the Hospital Incident Report. Allowing litigants like this plaintiff to obtain confidential peer review, such as the Hospital Incident Report, would undermine the Legislature's goal "to foster aggressive critiquing of medical care by the provider's peers." Beth Israel, supra, 401 Mass. at 182.

III. PURSUANT TO MASS. R. CIV. P. 26(c), THIS COURT SHOULD ENTER A PROTECTIVE ORDER PROTECTING ALL PEER REVIEW DOCUMENTS AND INFORMATION FROM DISCOVERY.

Rule 26(c) provides that "upon motion ... and for good cause shown, the Court in which the action is pending ... may make any order which justice requires to protect a party or person from annoyance, embarrassment, oppression or undue burden or expense including one or more of the following: (4) that certain matters not be inquired into, or that the scope of the discovery be limited to certain matters...." On the basis of this Rule and the statutes and regulations governing "peer review," the defendants request that the Court enter a protective order precluding the plaintiff from pursuing any discovery of confidential peer review.

More then just the Hospital Incident Report is confidential under M.G.L. c. 111, §204 and §205. §204(a) provides:

> no person who was in attendance at a meeting of a peer review committee shall be permitted or required to testify in any such judicial or administrative proceeding...as to the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, deliberations or other actions of such committee or any members thereof.

In addition, sec. 204(b) states in part:

> that in no event shall the identity of any person furnishing information or opinions to the committee be disclosed without the permission of such person.

Finally, sec, 204(c) states in part:

> that committee members may not be questioned in any proceeding about the identity of any person furnishing information or opinions to the committee, opinions formed by them as a result of such committee proceedings, or about the deliberations of such committee.

Therefore, this Court should enter a Protective Order and protect from disclosure the identities of all participants in any peer review concerning the plaintiff, preserve the confidentiality of all documents and information relied on by the PCAC, and preclude the plaintiff from inquiring from any witness the information relied upon by the Patient Care Assessment Committee, as well as all opinions and conclusions made by the Committee and any representatives on its behalf.

CONCLUSION

For all the foregoing reasons, the defendants request that the plaintiff's motion to compel the production of documents by New England Baptist Hospital be denied in its entirety, and that the Court enter a protective order providing as follows:

1. The identities of all persons who were interviewed or furnished information relating to the care rendered to the plaintiff to any peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee, and any representative thereof, shall remain confidential and immune from discovery;

2. The contents of all records and reports, including an internal incident report, relating to the plaintiff which were generated to comply with the defendant's risk management and/or quality assurance programs and which were necessary to the work-product of a medical peer review committee at New England Baptist Hospital, including the Patient Care Assessment Committee shall remain confidential and immune from discovery; and

3. All deliberations, opinions, conclusions and actions taken by a medical peer review committee affiliated with New England Baptist Hospital, including the Patient Care Assessment Committee and any representative thereof, relating to the plaintiff shall remain confidential and immune from discovery.

The Defendants,
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Error in Medicine

Lucian L. Leape, MD

FOR YEARS, medical and nursing students have been taught Florence Nightingale's dictum—first, do no harm.[1] Yet evidence from a number of sources, reported over several decades, indicates that a substantial number of patients suffer treatment-caused injuries while in the hospital.[2-6]

In 1964 Schimmel[2] reported that 20% of patients admitted to a university hospital medical service suffered iatrogenic injury and that 20% of those injuries were serious or fatal. Steel et al[3] found that 36% of patients admitted to a university medical service in a teaching hospital suffered an iatrogenic event, of which 25% were serious or life threatening. More than half of the injuries were related to use of medication.[3] In 1991 Bedell et al[4] reported the results of an analysis of cardiac arrests at a teaching hospital. They found that 64% were preventable. Again, inappropriate use of drugs was the leading cause of the cardiac arrests. Also in 1991, the Harvard Medical Practice Study reported the results of a population-based study of iatrogenic injury in patients hospitalized in New York State in 1984.[5,6] Nearly 4% of patients suffered an injury that prolonged their hospital stay or resulted in measurable disability. For New York State, this equaled 98 609 patients in 1984. Nearly 14% of these injuries were fatal. If these rates are typical of the United States, then 180 000 people die each year partly as a result of iatrogenic injury, the equivalent of three jumbo-jet crashes every 2 days.

When the causes are investigated, it is found that most iatrogenic injuries are due to errors and are, therefore, potentially preventable.[4,7,8] For example, in the Harvard Medical Practice Study, 69% of injuries were due to errors (the balance was unavoidable).[8] Error may be defined as an unintended act (either of omission or commission) or one that does not achieve its intended outcome. Indeed, injuries are but the "tip of the iceberg" of the problem of errors, since most errors do not result in patient injury. For example, medication errors occur in 2% to 14% of patients admitted to hospitals,[9-12] but most do not result in injury.[13]

Aside from studies of medication errors, the literature on medical error is sparse, in part because most studies of iatrogenesis have focused on injuries (eg, the Harvard Medical Practice Study). When errors have been specifically looked for, however, the rates reported have been distressingly high. Autopsy studies have shown high rates (35% to 40%) of missed diagnoses causing death.[14-16] One study of errors in a medical intensive care unit revealed an average of 1.7 errors per day per patient, of which 29% had the potential for serious or fatal injury.[17] Operational errors (such as failure to treat promptly or to get a follow-up culture) were found in 52% of patients in a study of children with positive urine cultures.[18]

For editorial comment see p 1867.

Given the complex nature of medical practice and the multitude of interventions that each patient receives, a high error rate is perhaps not surprising. The patients in the intensive care unit study, for example, were the recipients of an average of 178 "activities" per day. The 1.7 errors per day thus indicate that hospital personnel were functioning at a 99% level of proficiency. However, a 1% failure rate is substantially higher than is tolerated in industry, particularly in hazardous fields such as aviation and nuclear power. As W. E. Deming points out (written communication, November 1987), even 99.9% may not be good enough: "If we had to live with 99.9%, we would have: 2 unsafe plane landings per day at O'Hare, 16 000 pieces of lost mail every hour, 32 000 bank checks deducted from the wrong bank account every hour."

WHY IS THE ERROR RATE IN THE PRACTICE OF MEDICINE SO HIGH?

Physicians, nurses, and pharmacists are trained to be careful and to function at a high level of proficiency. Indeed, they probably are among the most careful professionals in our society. It is curious, therefore, that high error rates have not stimulated more concern and efforts at error prevention. One reason may be a lack of awareness of the severity of the problem. Hospital-acquired injuries are not reported in the newspapers like jumbo-jet crashes, for the simple reason that they occur one at a time in 5000 different locations across the country. Although error rates are substantial, serious injuries due to errors are not part of the everyday experience of physicians or nurses, but are perceived as isolated and unusual events—"outliers." Second, most errors do no harm. Either they are intercepted or the patient's defenses prevent injury. (Few children die from a single misdiagnosed or mistreated urinary infection, for example.)

But the most important reason physicians and nurses have not developed more effective methods of error prevention is that they have a great deal of difficulty in dealing with human error when it does occur.[19-21] The reasons are to be found in the culture of medical practice.

Physicians are socialized in medical school and residency to strive for error-free practice.[19] There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians, not unlike test pilots, come to view an error as a failure of character—you weren't careful enough, you didn't try hard enough. This kind of thinking lies behind a common reaction by physicians: "How can there be an error without negligence?"

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Cultivating a norm of high standards is, of course, highly desirable. It is the counterpart of another fundamental goal of medical education: developing the physician's sense of responsibility for the patient. If you are responsible for everything that happens to the patient, it follows that you are responsible for any errors that occur. While the logic may be sound, the conclusion is absurd, because physicians do not have the power to control all aspects of patient care.[22] Nonetheless, the sense of duty to perform faultlessly is strongly internalized.

Role models in medical education reinforce the concept of infallibility. The young physician's teachers are largely specialists, experts in their fields, and authorities. Authorities are not supposed to err. It has been suggested that this need to be infallible creates a strong pressure to intellectual dishonesty, to cover up mistakes rather than to admit them.[23] The organization of medical practice, particularly in the hospital, perpetuates these norms. Errors are rarely admitted or discussed among physicians in private practice. Physicians typically feel, not without reason, that admission of error will lead to censure or increased surveillance or, worse, that their colleagues will regard them as incompetent or careless. Far better to conceal a mistake or, if that is impossible, to try to shift the blame to another, even the patient.

Yet physicians are emotionally devastated by serious mistakes that harm or kill patients.[19-21] Almost every physician who cares for patients has had that experience, usually more than once. The emotional impact is often profound, typically a mixture of fear, guilt, anger, embarrassment, and humiliation. However, as Christensen et al[20] note, physicians are typically isolated by their emotional responses; seldom is there a process to evaluate the circumstances of a mistake and to provide support and emotional healing for the fallible physician. Wu et al[21] found that only half of house officers discussed their most significant mistakes with attending physicians.

Thus, although the individual may learn from a mistake and change practice patterns accordingly, the adjustment often takes place in a vacuum. Lessons learned are shared privately, if at all, and external objective evaluation of what went wrong often does not occur. As Hilfiker[19] points out. "We see the horror of our own mistakes, yet we are given no permission to deal with their enormous emotional impact. . . . The medical profession simply has no place for its mistakes."

Finally, the realities of the malpractice threat provide strong incentives against disclosure or investigation of mistakes. Even a minor error can place the physician's entire career in jeopardy if it results in a serious bad outcome. It is hardly surprising that a physician might hesitate to reveal an error to either the patient or hospital authorities or to expose a colleague to similar devastation for a single mistake.

The paradox is that although the standard of medical practice is perfection—error-free patient care—all physicians recognize that mistakes are inevitable. Most would like to examine their mistakes and learn from them. From an emotional standpoint, they need the support and understanding of their colleagues and patients when they make mistakes. Yet, they are denied both insight and support by misguided concepts of infallibility and by fear: fear of embarrassment by colleagues, fear of patient reaction, and fear of litigation. Although the notion of infallibility fails the reality test, the fears are well grounded.

THE MEDICAL APPROACH TO ERROR PREVENTION

Efforts at error prevention in medicine have characteristically followed what might be called the perfectibility model: if physicians and nurses could be properly trained and motivated, then they would make no mistakes. The methods used to achieve this goal are training and punishment. Training is directed toward teaching people to do the right thing. In nursing, rigid adherence to protocols is emphasized. In medicine, the emphasis is less on rules and more on knowledge.

Punishment is through social opprobrium or peer disapproval. The professional cultures of medicine and nursing typically use blame to encourage proper performance. Errors are regarded as someone's fault, caused by a lack of sufficient attention or, worse, lack of caring enough to make sure you are correct. Punishment for egregious (negligent) errors is primarily (and capriciously) meted out through the malpractice tort litigation system.

Students of error and human performance reject this formulation. While the proximal error leading to an accident is, in fact, usually a "human error," the causes of that error are often well beyond the individual's control. All humans err frequently. Systems that rely on error-free performance are doomed to fail.

The medical approach to error prevention is also reactive. Errors are usually discovered only when there is an incident—an untoward effect or injury to the patient. Corrective measures are then directed toward preventing a recurrence of a similar error, often by attempting to prevent *that* individual from making a repeat error. Seldom are underlying causes explored.

For example, if a nurse gives a medication to the wrong patient, a typical response would be exhortation or training in double-checking the identity of both patient and drug before administration. Although it might be noted that the nurse was distracted because of an unusually large case load, it is unlikely that serious attention would be given to evaluating overall work assignments or to determining if large case loads have contributed to other kinds of errors.

It is even less likely that questions would be raised about the wisdom of a system for dispensing medications in which safety is contingent on inspection by an individual at the end point of use. Reliance on inspection as a mechanism of quality control was discredited long ago in industry.[24,25] A simple procedure, such as the use of bar coding like that used at supermarket checkout counters, would probably be more effective in this situation. More imaginative solutions could easily be found—if it were recognized that both systems and individuals contribute to the problem.

It seems clear, and it is the thesis of this article, that if physicians, nurses, pharmacists, and administrators are to succeed in reducing errors in hospital care, they will need to fundamentally change the way they think about errors and why they occur. Fortunately, a great deal has been learned about error prevention in other disciplines, information that is relevant to the hospital practice of medicine.

LESSONS FROM PSYCHOLOGICAL AND HUMAN FACTORS RESEARCH

The subject of human error has long fascinated psychologists and others, but both the development of theory and the pace of empirical research accelerated in response to the dramatic technological advances that occurred during and after World War II.[26] These theory development and research activities followed two parallel and intersecting paths: human factors research and cognitive psychology.

Human factor specialists, mostly engineers, have been largely concerned with the design of the man-machine interface in complex environments such as airplane cockpits and nuclear power plant control rooms. Cognitive psychologists concentrated on developing models of human cognition that they subjected to empirical testing. Lessons from both spheres of observation have greatly deepened our understanding of mental

functioning. We now have reasonably coherent theories of why humans err, and a great deal has been learned about how to design work environments to minimize the occurrence of errors and limit their consequences.

A THEORY OF COGNITION

Most errors result from aberrations in mental functioning. Thus, to understand why errors occur we must first understand normal cognition. Although many theories have been espoused, and experts disagree, a unitary framework has been proposed by Reason[26] that captures the main themes of cognitive theory and is consistent with empirical observation. It goes as follows.

Much of mental functioning is automatic, rapid, and effortless. A person can leave home, enter and start the car, drive to work, park, and enter the office without devoting much conscious thought to any of the hundreds of maneuvers and decisions that this complex set of actions requires. This automatic and unconscious processing is possible because we carry a vast array of mental models, "schemata" in psychological jargon, that are "expert" on some minute recurrent aspect of our world. These schemata operate briefly when required, processing information rapidly, in parallel, and without conscious effort. Schemata are activated by conscious thought or sensory inputs; functioning thereafter is automatic.

In addition to this automatic unconscious processing, called the "schematic control mode," cognitive activities can be conscious and controlled. This "attentional control mode" or conscious thought is used for problem solving as well as to monitor automatic function. The attentional control mode is called into play when we confront a problem, either de novo or as a result of failures of the schematic control mode. In contrast to the rapid parallel processing of the schematic control mode, processing in the attentional control mode is slow, sequential, effortful, and difficult to sustain.

Rasmussen and Jensen[27] describe a model of performance based on this concept of cognition that is particularly well suited for error analysis. They classify human performance into three levels: (1) skill-based, which is patterns of thought and action that are governed by stored patterns of preprogrammed instructions (schemata) and largely unconscious; (2) rule-based, in which solutions to familiar problems are governed by stored rules of the "if X, then Y" variety; and (3) knowledge-based, or synthetic thought, which is used for novel situations requiring conscious analytic processing and stored knowledge.

Any departure from routine, ie, a problem, requires a rule-based or knowledge-based solution. Humans prefer pattern recognition to calculation, so they are strongly biased to search for a prepackaged solution, ie, a "rule," before resorting to more strenuous knowledge-based functioning.

Although all three levels may be used simultaneously, with increasing expertise the primary focus of control moves from knowledge-based toward skill-based functioning. Experts have a much larger repertoire of schemata and problem-solving rules than novices, and they are formulated at a more abstract level. In one sense, expertise means seldom having to resort to knowledge-based functioning (reasoning).

MECHANISMS OF COGNITIVE ERRORS

Errors have been classified by Reason and Rasmussen at each level of the skill-, rule-, and knowledge-based model.[26] Skill-based errors are called "slips." These are unconscious glitches in automatic activity. Slips are errors of action. Rule-based and knowledge-based errors, by contrast, are errors of conscious thought and are termed "mistakes." The mechanisms of error vary with the level.

Slips

Skill-based activity is automatic. A slip occurs when there is a break in the routine while attention is diverted. The actor possesses the requisite routines; errors occur because of a lack of a timely attentional check. In brief, slips are monitoring failures. They are unintended acts.

A common mechanism of a slip is *capture*, in which a more frequently used schema takes over from a similar but less familiar one. For example, if the usual action sequence is ABCDE, but on this occasion the planned sequence changes to ABCFG, then conscious attention must be in force after C or the more familiar pattern DE will be executed. An everyday example is departing on a trip in which the first part of the journey is the same as a familiar commuting path and driving to work instead of to the new location.

Another type of slip is a *description error*, in which the right action is performed on the wrong object, such as pouring cream on a pancake. *Associative activation errors* result from mental associations of ideas, such as answering the phone when the doorbell rings. *Loss of activation errors* are temporary memory losses, such as entering a room and no longer remembering why you wanted to go there. Loss of activation errors are frequently caused by interruptions.

A variety of factors can divert attentional control and make slips more likely. Physiological factors include fatigue, sleep loss, alcohol, drugs, and illness. Psychological factors include other activity ("busyness"), as well as emotional states such as boredom, frustration, fear, anxiety, or anger. All these factors lead to preoccupations that divert attention. Psychological factors, though considered "internal" or endogenous, may also be caused by a host of external factors, such as overwork, interpersonal relations, and many other forms of stress. Environmental factors, such as noise, heat, visual stimuli, motion, and other physical phenomena, also can cause distractions that divert attention and lead to slips.

Mistakes

Rule-based errors usually occur during problem solving when a wrong rule is chosen—either because of a misperception of the situation and, thus, the application of a wrong rule or because of misapplication of a rule, usually one that is strong (frequently used), that seems to fit adequately. Errors result from misapplied expertise.

Knowledge-based errors are much more complex. The problem solver confronts a novel situation for which he or she possesses no preprogrammed solutions. Errors arise because of lack of knowledge or misinterpretation of the problem. Pattern matching is preferred to calculation, but sometimes we match the wrong patterns. Certain habits of thought have been identified that alter pattern matching or calculation and lead to mistakes. These processes are incompletely understood and are seldom recognized by the actor. One such process is *biased memory*. Decisions are based on what is in our memory, but memory is biased toward overgeneralization and overregularization of the commonplace.[28] Familiar patterns are assumed to have universal applicability because they usually work. We see what we know. Paradoxically, memory is also biased toward overemphasis on the discrepant. A contradictory experience may leave an exaggerated impression far outweighing its statistical importance (eg, the exceptional case or missed diagnosis).

Another mechanism is the *availability heuristic*,[29] the tendency to use the first information that comes to mind. Related are *confirmation bias*, the tendency to look for evidence that supports an early working hypothesis and to ignore data that contradict it, and *overconfidence*, the tendency to believe in the validity of the chosen course of action and to focus on evidence that favors it.[26]

Rule-based and knowledge-based functioning are affected by the same physiological, psychological, and environmental influences that produce slips. A great deal of research has been devoted to the effects of stress on performance. Although it is often difficult to establish causal links between stress and specific accidents, there is little question that errors (both slips and mistakes) are increased under stress. On the other hand, stress is not all bad. It has long been known that "a little anxiety improves performance." In 1908, Yerkes and Dodson[30] showed that performance is best at moderate levels of arousal. Poor performance occurs at both extremes: boredom and panic.[31] *Coning of attention* under stress is the tendency in an emergency to concentrate on one single source of information, the "first come, best preferred" solution.[31] (A classic example is the phenomenon of passengers in a crashed aircraft struggling to open a door while ignoring a large hole in the fuselage a few feet away.) *Reversion under stress* is a phenomenon in which recently learned behavioral patterns are replaced by older, more familiar ones, even if they are inappropriate in the circumstances.[31]

The complex nature of cognition, the vagaries of the physical world, and the inevitable shortages of information and schemata ensure that normal humans make multiple errors every day. Slips are most common, since much of our mental functioning is automatic, but the rate of error in knowledge-based processes is higher.[26]

LATENT ERRORS

In 1979, the Three-Mile Island incident caused both psychologists and human factors engineers to reexamine their theories about human error. Although investigations revealed the expected operator errors, it was clear that prevention of many of these errors was beyond the capabilities of the human operators at the time. Many errors were caused by faulty interface design, others by complex interactions and breakdowns that were not discernible by the operators or their instruments. The importance of poor system design as a cause of failures in complex processes became more apparent.[32] Subsequent disasters, notably Bhopal and Chernobyl, made it even clearer that operator errors were only part of the explanation of failures in complex systems. Disasters of this magnitude resulted from major failures of design and organization that occurred long before the accident, failures that both caused operator errors and made them impossible to reverse.[26,32]

Reason[26] has called these *latent errors*, errors that have effects that are delayed, "accidents waiting to happen," in contrast to active errors, which have effects that are felt immediately. While an operator error may be the proximal "cause" of the accident, the root causes were often present within the system for a long time. The operator has, in a real sense, been "set up" to fail by poor design, faulty maintenance, or erroneous management decisions.

Faulty design at Three-Mile Island provided gauges that gave a low pressure reading both when pressure was low and when the gauge was not working and a control panel on which 100 warning lights flashed simultaneously. Faulty maintenance disabled a safety back-up system so the operator could not activate it when needed. Similarly, bad management decisions can result in unrealistic workloads, inadequate training, and demanding production schedules that lead workers to make errors.

Accidents rarely result from a single error, latent or active.[28,32] System defenses and the abilities of frontline operators to identify and correct errors before an accident occurs make single-error accidents highly unlikely. Rather, accidents typically result from a combination of latent and active errors and breach of defenses. The precipitating event can be a relatively trivial malfunction or an external circumstance, such as the weather (eg, the freezing of O-rings that caused the Challenger disaster).

The most important result of latent errors may be the production of psychological precursors, which are pathologic situations that create working conditions that predispose to a variety of errors.[26] Inappropriate work schedules, for example, can result in high workloads and undue time pressures that induce errors. Poor training can lead to inadequate recognition of hazards or inappropriate procedures that lead to accidents. Conversely, a precursor can be the product of more than one management or training failure. For example, excessive time pressure can result from poor scheduling, but it can also be the product of inadequate training or faulty division of responsibilities. Because they can affect all cognitive processes, these precursors can cause an immense variety of errors that result in unsafe acts.

The important point is that successful accident prevention efforts must focus on root causes—system errors in design and implementation. It is futile to concentrate on developing solutions to the unsafe acts themselves. Other errors, unpredictable and infinitely varied, will soon occur if the underlying cause is uncorrected. Although correcting root causes will not eliminate all errors—individuals still bring varying abilities and work habits to the workplace—it can significantly reduce the probability of errors occurring.

PREVENTION OF ACCIDENTS

The multiplicity of mechanisms and causes of errors (internal and external, individual and systemic) dictates that there cannot be a simple or universal means of reducing errors. Creating a safe process, whether it be flying an airplane, running a hospital, or performing cardiac surgery, requires attention to methods of error reduction at each stage of system development: design, construction, maintenance, allocation of resources, training, and development of operational procedures. This type of attention to error reduction requires responsible individuals at each stage to think through the consequences of their decisions and to reason back from discovered deficiencies to redesign and reorganize the process. Systemic changes are most likely to be successful because they reduce the likelihood of a variety of types of errors at the end-user stage.

The primary objective of system design for safety is to make it difficult for individuals to err. But it is also important to recognize that errors will inevitably occur and plan for their recovery.[26] Ideally, the system will automatically correct errors when they occur. If that is impossible, mechanisms should be in place to at least detect errors in time for corrective action. Therefore, in addition to designing the work environment to minimize psychological precursors, designers should provide feedback through instruments that provide monitoring functions and build in buffers and redundancy. Buffers are design features that automatically correct for human or mechanical errors. Redundancy is duplication (sometimes triplication or quadruplication) of critical mechanisms and instruments, so that a failure does not result in loss of the function.

Another important system design feature is designing tasks to minimize errors. Norman[28] has recommended a set of principles that have general applicability. Tasks should be *simplified* to minimize the load on the weakest aspects of cognition: short-term memory, planning, and problem solving. The power of *constraints* should be exploited. One way to do this is with "forcing functions," which make it impossible to act without meeting a precondition (such as the inability to release the parking gear of a car unless the brake pedal is depressed). *Standardization* of procedures, displays, and layouts reduces error by reinforcing the pattern recognition that humans do well.

Finally, where possible, operations should be easily *reversible* or difficult to perform when they are not reversible.

Training must include, in addition to the usual emphasis on application of knowledge and following procedures, a consideration of safety issues. These issues include understanding the rationale for procedures as well as how errors can occur at various stages, their possible consequences, and instruction in methods for avoidance of errors. Finally, it must be acknowledged that injuries can result from behavioral problems that may be seen in impaired physicians or incompetent physicians despite well-designed systems; methods for identifying and correcting egregious behaviors are also needed.

THE AVIATION MODEL

The practice of hospital medicine has been compared, usually unfavorably, to the aviation industry, also a highly complicated and risky enterprise but one that seems far safer. Indeed, there seem to be many similarities. As Allnutt observed,

> Both pilots and doctors are carefully selected, highly trained professionals who are usually determined to maintain high standards, both externally and internally imposed, whilst performing difficult tasks in life-threatening environments. Both use high technology equipment and function as key members of a team of specialists . . . both exercise high level cognitive skills in a most complex domain about which much is known, but where much remains to be discovered.[31]

While the comparison is apt, there are also important differences between aviation and medicine, not the least of which is a substantial measure of uncertainty due to the number and variety of disease states, as well as the unpredictability of the human organism. Nonetheless, there is much physicians and nurses could learn from aviation.

Aviation—airline travel, at least—is indeed generally safe: more than 10 million takeoffs and landings each year with an average of fewer than four crashes a year. But, it was not always so. The first powered flight was in 1903, the first fatality in 1908, and the first midair collision in 1910. By 1910, there were 2000 pilots in the world and 32 had already died.[32] The US Air Mail Service was founded in 1918. As a result of efforts to meet delivery schedules in all kinds of weather, 31 of the first 40 Air Mail Service pilots were killed. This appalling toll led to unionization of the pilots and their insistence that local field controllers could not order pilots to fly against their judgment unless the field controllers went up for a flight around the field themselves. In 1922, there were no Air Mail Service fatalities.[32] Since that time, a complex system of aircraft design, instrumentation, training, regulation, and air traffic control has developed that is highly effective at preventing fatalities.

There are strong incentives for making flying safe. Pilots, of course, are highly motivated. Unlike physicians, their lives are on the line as well as those of their passengers. But, airlines and airplane manufacturers also have strong incentives to provide safe flight. Business decreases after a large crash, and if a certain model of aircraft crashes repeatedly, the manufacturer will be discredited. The lawsuits that inevitably follow a crash can harm both reputation and profitability.

Designing for safety has led to a number of unique characteristics of aviation that could, with suitable modification, prove useful in improving hospital safety.

First, in terms of system design, aircraft designers assume that errors and failures are inevitable and design systems to "absorb" them, building in multiple buffers, automation, and redundancy. As even a glance in an airliner cockpit reveals, extensive feedback is provided by means of monitoring instruments, many in duplicate or triplicate. Indeed, the multiplicity of instruments and automation have generated their own challenges to system design: sensory overload and boredom. Nonetheless, these safeguards have served the cause of aviation safety well.

Second, procedures are standardized to the maximum extent possible. Specific protocols must be followed for trip planning, operations, and maintenance. Pilots go through a checklist before each takeoff. Required maintenance is specified in detail and must be performed on a regular (by flight hours) basis. Third, the training, examination, and certification process is highly developed and rigidly, as well as frequently, enforced. Airline pilots take proficiency examinations every 6 months. Much of the content of examinations is directly concerned with procedures to enhance safety.

Pilots function well within this rigorously controlled system, although not flawlessly. For example, one study of cockpit crews observed that human errors or instrument malfunctions occurred on the average of one every 4 minutes during an overseas flight.[32] Each event was promptly recognized and corrected with no untoward effects. Pilots also willingly submit to an external authority, the air traffic controller, when within the constrained air and ground space at a busy airport.

Finally, safety in aviation has been institutionalized. Two independent agencies have government-mandated responsibilities: the Federal Aviation Administration (FAA) regulates all aspects of flying and prescribes safety procedures, and the National Transportation Safety Board investigates every accident. The adherence of airlines and pilots to required safety standards is closely monitored. The FAA recognized long ago that pilots seldom reported an error if it led to disciplinary action. Accordingly, in 1975 the FAA established a confidential reporting system for safety infractions, the Air Safety Reporting System (ASRS). If pilots, controllers, or others promptly report a dangerous situation, such as a near-miss midair collision, they will not be penalized. This program dramatically increased reporting, so that unsafe conditions at airports, communication problems, and traffic control inadequacies are now promptly communicated. Analysis of these reports and subsequent investigations appear as a regular feature in several pilots' magazines. The ASRS receives more than 5000 notifications each year.[32]

THE MEDICAL MODEL

By contrast, accident prevention has not been a primary focus of the practice of hospital medicine. It is not that errors are ignored. Mortality and morbidity conferences, incident reports, risk management activities, and quality assurance committees abound. But, as noted previously, these activities focus on incidents and individuals. When errors are examined, a problem-solving approach is usually used: the cause of the error is identified and corrected. Root causes, the underlying systems failures, are rarely sought. System designers do not assume that errors and failures are inevitable and design systems to prevent or absorb them. There are, of course, exceptions. Implementation of unit dosing, for example, markedly reduced medication dosing errors by eliminating the need for the nurse to measure out each dose. Monitoring in intensive care units is sophisticated and extensive (although perhaps not sufficiently redundant). Nonetheless, the basic health care system approach is to rely on individuals not to make errors rather than to assume they will.

Second, standardization and task design vary widely. In the operating room, it has been refined to a high art. In patient care units, much more could be done, particularly to minimize reliance on short-term memory, one of the the weakest aspects of cognition. On-time and correct delivery of medications, for

example, is often contingent on a busy nurse remembering to do so. a nurse who is responsible for four or five patients at once and is repeatedly interrupted, a classic set up for a "loss-of-activation" error.

On the other hand, education and training in medicine and nursing far exceed that in aviation, both in breadth of content and in duration, and few professions compare with medicine in terms of the extent of continuing education. Although certification is essentially universal, including the recent introduction of periodic recertification, the idea of periodically testing *performance* has never been accepted. Thus, we place great emphasis on education and training, but shy away from demonstrating that it makes a difference.

Finally, unlike aviation, safety in medicine has never been institutionalized, in the sense of being a major focus of hospital medical activities. Investigation of accidents is often superficial, unless a malpractice action is likely; noninjurious error (a "near miss") is rarely examined at all. Incident reports are frequently perceived as punitive instruments. As a result, they are often not filed, and when they are, they almost invariably focus on the individual's misconduct.

One medical model is an exception and has proved quite successful in reducing accidents due to errors: anesthesia. Perhaps in part because the effects of serious anesthetic errors are potentially so dramatic—death or brain damage—and perhaps in part because the errors are frequently transparently clear and knowable to all, anesthesiologists have greatly emphasized safety. The success of these efforts has been dramatic. Whereas mortality from anesthesia was one in 10 000 to 20 000 just a decade or so ago, it is now estimated at less than one in 200 000.[33] Anesthesiologists have led the medical profession in recognizing system factors as causes of errors, in designing fail-safe systems, and in training to avoid errors.[34-36]

SYSTEMS CHANGES TO REDUCE HOSPITAL INJURIES

Can the lessons from cognitive psychology and human factors research that have been successful in accident prevention in aviation and other industries be applied to the practice of hospital medicine? There is every reason to think they could be. Hospitals, physicians, nurses, and pharmacists who wish to reduce errors could start by considering how cognition and error mechanisms apply to the practice of hospital medicine. Specifically, they can examine their care delivery systems in terms of the systems' ability to discover, prevent, and absorb errors and for the presence of psychological precursors.

Discovery of Errors

The first step in error prevention is to define the problem. Efficient, routine identification of errors needs to be part of hospital practice, as does routine investigation of all errors that cause injuries. The emphasis is on "routine." Only when errors are accepted as an inevitable, although manageable, part of everyday practice will it be possible for hospital personnel to shift from a punitive to a creative frame of mind that seeks out and identifies the underlying system failures.

Data collecting and investigatory activities are expensive, but so are the consequences of errors. Evidence from industry indicates that the savings from reduction of errors and accidents more than make up for the costs of data collection and investigation.[31] (While these calculations apply to "rework" and other operational inefficiencies resulting from errors, additional savings from reduced patient care costs and liability costs for hospitals and physicians could also be substantial.)

Prevention of Errors

Many health care delivery systems could be redesigned to significantly reduce the likelihood of error. Some obvious mechanisms that can be used are as follows:

Reduced Reliance on Memory.—Work should be designed to minimize the requirements for human functions that are known to be particularly fallible, such as short-term memory and vigilance (prolonged attention). Clearly, the components of work must be well delineated and understood before system redesign. Checklists, protocols, and computerized decision aids could be used more widely. For example, physicians should not have to rely on their memories to retrieve a laboratory test result, and nurses should not have to remember the time a medication dose is due. These are tasks that computers do much more reliably than humans.

Improved Information Access.—Creative ways need to be developed for making information more readily available: displaying it where it is needed, when it is needed, and in a form that permits easy access. Computerization of the medical record, for example, would greatly facilitate bedside display of patient information, including tests and medications.

Error Proofing.—Where possible, critical tasks should be structured so that errors cannot be made. The use of "forcing functions" is helpful. For example, if a computerized system is used for medication orders, it can be designed so that a physician cannot enter an order for a lethal overdose of a drug or prescribe a medication to which a patient is known to be allergic.

Standardization.—One of the most effective means of reducing error is standardizing processes wherever possible. The advantages, in efficiency as well as in error reduction, of standardizing drug doses and times of administration are obvious. Is it really acceptable to ask nurses to follow six different "K-scales" (directions for how much potassium to give according to patient serum potassium levels) solely to satisfy different physician prescribing patterns? Other candidates for standardization include information displays, methods for common practices (such as surgical dressings), and the geographic location of equipment and supplies in a patient care unit. There is something bizarre, and really quite inexcusable, about "code" situations in hospitals where house staff and other personnel responding to a cardiac arrest waste precious seconds searching for resuscitation equipment simply because it is kept in a different location on each patient care unit.

Training.—Instruction of physicians, nurses, and pharmacists in procedures or problem solving should include greater emphasis on possible errors and how to prevent them. (Well-written surgical atlases do this.) For example, many interns need more rigorous instruction and supervision than is currently provided when they are learning new procedures. Young physicians need to be taught that safe practice is as important as effective practice. Both physicians and nurses need to learn to think of errors primarily as symptoms of systems failures.

Absorption of Errors

Because it is impossible to prevent all error, buffers should be built into each system so that errors are absorbed before they can cause harm to patients. At minimum, systems should be designed so that errors can be identified in time to be intercepted. The drug delivery systems in most hospitals do this to some degree already. Nurses and pharmacists often identify errors in physician drug orders and prevent improper administration to the patient. As hospitals move to computerized records and ordering systems, more of these types of interceptions can be incorporated into the computer programs. Critical systems (such as life-support equipment and monitors) should be provided in duplicate in those situations in which a me-

chanical failure could lead to patient injury.

Psychological Precursors

Finally, explicit attention should be given to work schedules, division of responsibilities, task descriptions, and other details of working arrangements where improper managerial decisions can produce psychological precursors such as time pressures and fatigue that create an unsafe environment. While the influence of the stresses of everyday life on human behavior cannot be eliminated, stresses caused by a faulty work environment can be. Elimination of fear and the creation of a supportive working environment are other potent means of preventing errors.

INSTITUTIONALIZATION OF SAFETY

Although the idea of a national hospital safety board that would investigate every accident is neither practical nor necessary, at the hospital level such activities should occur. Existing hospital risk management activities could be broadened to include all potentially injurious errors and deepened to seek out underlying system failures. Providing immunity, as in the FAA ASRS system, might be a good first step. At the national level, the Joint Commission on Accreditation of Healthcare Organizations should be involved in discussions regarding the institutionalization of safety. Other specialty societies might well follow the lead of the anesthesiologists in developing safety standards and require their instruction to be part of residency training.

IMPLEMENTING SYSTEMS CHANGES

Many of the principles described herein fit well within the teachings of total quality management.[24] One of the basic tenants of total quality management, statistical quality control, requires data regarding variation in processes. In a generic sense, errors are but variations in processes. Total quality management also requires a culture in which errors and deviations are regarded not as human failures, but as opportunities to improve the system, "gems," as they are sometimes called. Finally, total quality management calls for grassroots participation to identify and develop system modifications to eliminate the underlying failures.

Like total quality management, systems changes to reduce errors require commitment of the organization's leadership. None of the aforementioned changes will be effective or, for that matter, even possible without support at the highest levels (hospital executives and departmental chiefs) for making safety a major goal of medical practice.

But it is apparent that the most fundamental change that will be needed if hospitals are to make meaningful progress in error reduction is a cultural one. Physicians and nurses need to accept the notion that error is an inevitable accompaniment of the human condition, even among conscientious professionals with high standards. Errors must be accepted as evidence of systems flaws not character flaws. Until and unless that happens, it is unlikely that any substantial progress will be made in reducing medical errors.

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tic use when the drug is taken in higher-than-recommended doses, and patients who have recently been fasting may be at greater risk of this serious adverse reaction. These findings are of interest pathophysiologically. However, given the rarity of this condition when this drug is used in recommended doses, these data do not necessarily indicate that alcohol abusers or fasting patients should avoid using acetaminophen in favor of other over-the-counter analgesics such as salicylates or other nonsteroidal anti-inflammatory drugs (NSAIDs). These other analgesics are associated with gastrointestinal bleeding, which is also not common but occurs with a significantly greater incidence than acetaminophen-induced hepatotoxicity. Based on US vital statistics data, hospitalizations for upper gastrointestinal bleeding occur on the order of 1.5 cases per 1000 people per year,[7] and NSAIDs increase this risk further. In addition, recent data have demonstrated an additive effect of alcoholism and NSAID use, (ie, the incidence of NSAID-induced gastrointestinal bleeding is even greater in alcoholics).[8] Analogous data in humans on the effect of fasting on the risk of NSAID-induced gastrointestinal bleeding are not available. However, based on pathophysiology (ie, fasting patients would have a lower gastric pH) and analogous animal data (eg, in one animal model, gastric damage occurred in nonfed rats, but not in fed rats[9]), one might expect potentiation by fasting also. Therefore, if patients (especially alcoholics) were to switch from using acetaminophen to using salicylates or other NSAIDs, the number or cases or acetaminophen-induced hepatotoxicity that would be prevented would be dwarfed by the number of excess deaths from gastrointestinal bleeding. For this reason, in part, the Food and Drug Administration (FDA) advisory committees have recommended the implementation of a warning about use in alcoholics for all the over-the-counter analgesics; FDA action on this is expected imminently. In the meantime, the manufacturer of over-the-counter naproxen has already implemented such a warning, and at least one major manufacturer of acetaminophen is doing the same.

Therefore, despite these new data, acetaminophen remains the over-the-counter analgesic and antipyretic associated with the lowest risk of adverse reactions, even in alcoholics and fasting patients. However, patients should be careful not to use acetaminophen in doses greater than those recommended, and physicians should warn patients to avoid ingesting more than 4 g (or eight extra-strength tablets) in 24 hours. Acetaminophen, like all drugs, should be used only when necessary. Further, when ingested, users should not automatically use it in maximum daily dose, especially when ingesting the extra-strength formulation. Patients also should be careful that they are not taking multiple acetaminophen-containing drugs simultaneously, and physicians should take a thorough over-the-counter medication history, especially when evaluating patients presenting with liver disease. To assure safety, acetaminophen, like all analgesics, should be used in a dose no larger and with a frequency no more common than that needed for adequate symptom relief.

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Making Medical Errors Into 'Medical Treasures'

In his insightful and provocative article on medical error, Leape[1] raises a topic that has been distinctly unpopular among physicians. Concerning medical error and its prevention, the profession has, with rare exceptions, adopted an ostrichlike attitude. Mistakes have been treated as uncommon and atypical, requiring no remedy beyond the traditional incident reports and morbidity and mortality conferences.

The manner in which physicians manage medical errors must and will change in the future. It will change because a large and growing collection of literature demonstrates that physicians' approaches to the management of medical error do not work well enough, and the various parties to which physicians are accountable—purchasers, payers, government, and the public—have discovered this fact. The only question now is whether new systems for preventing medical error will be designed with the full cooperation and participation of the profession or under less desirable circumstances. The

See also p 1851.

increasing role of physicians in the development and dissemination of practice guidelines is an encouraging development in this regard, but more fundamental changes will be required.[2]

For physicians to play a more constructive role in error prevention, a number of difficult challenges must be overcome, and not all of them are under the control of the pro-

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fession itself. The first challenge is that attitudes toward error must change among both physicians and the public. This change will require, in turn, that both patients and physicians abandon cherished myths.

Throughout most of this century, the public has granted physicians extraordinary autonomy and power in return for an implied promise that, among other things, physicians would guarantee the quality of care patients receive.[3] Implicit in this social contract was the belief on both sides that physicians have the capability to practice error-free or nearly error-free medicine themselves and to ensure that the rest of the system functions just as well.[4] This belief has served the interests of both parties to this contract. Physicians have enjoyed the resulting status, freedom, and material rewards. Patients have enjoyed the reassuring fantasy that when they are ill, they can expect their physicians to make the health care system perform flawlessly.

Comfortable as this arrangement has been, it is proving dysfunctional. Physicians are encouraged to hold themselves to unattainable standards, to deny evidence of error, and thus to overlook opportunities for improving themselves and the health care system as a whole. When inevitable errors occur, patients feel betrayed and enraged. These feelings fuel the malpractice crisis that is itself a major deterrent to the openness required for quality improvement.[5]

The paradox of modern quality improvement is that only by admitting and forgiving error can its rate be minimized. For error reduction to occur, physicians must become more comfortable with their fallibility, and patients must become more accepting of their own vulnerability.

A second challenge facing physicians is an intellectual one that is well illustrated by Leape's analysis of the types and psychological causes of medical error. Physicians are trained to use the biomedical sciences in problem solving. These sciences are invaluable for understanding how to diagnose and treat illnesses in individual patients and how to interpret the flow of information that arises continuously from biomedical research. However, many scientific disciplines besides the biomedical sciences provide insight into ways to improve quality and ways to reduce the frequency of error in complex modern systems, such as the delivery of health care. Leape[1] demonstrates the potential use of cognitive psychology to prevent error in medical care. Berwick[6] has discussed the relevance of four general scientific areas to clinical quality improvement: the sciences of systems; the psychological sciences; the sciences of learning, prediction, and experiment; and the statistical sciences.

In addition to the analytic power offered by these nonbiomedical disciplines, a vast body of practical knowledge has been acquired through attempts to apply them for quality improvement purposes in various nonmedical, high-technology settings, such as aviation, nuclear power, and weapons production and design.[7] Modern quality management and improvement in industry, including the approach called total quality management, make use of many of these disciplines for the purpose of error prevention in manufacturing and service.[7] Widely used in industry, the technique of statistical quality control has enormous potential for alerting physicians and others to the occurrence of error in medical settings, so that it can be corrected promptly.[1,7,8] Some of the monitoring techniques now routinely used in anesthesia bear a close resemblance to statistical quality control and have played a role in reducing the frequency of anesthetic mishaps.

The intellectual challenge facing physicians is to accept and use these nonbiomedical disciplines and examples for the purpose of reducing medical error. This challenge will require overcoming medicine's own version of the "not invented here" syndrome. Physicians have not been quick to embrace insights gleaned from the nonbiomedical sciences and, until recently, have not shown any particular interest in learning from the experience of other industries about how to improve medical quality. In this, the profession has displayed a parochialism that seems inconsistent with its avowed commitment to professionalism and self-improvement.

Leape notes that in the jargon of total quality management, errors are sometimes called "gems." "Every defect is a treasure" is an aphorism that advocates of total quality management are fond of quoting. The notion is that the information contained in the study of mistakes is vital to improvements that will prevent those problems in the future.

On first inspection, these sayings are likely to convince physicians that it is naive and dangerous to import models from outside medicine when trying to reduce medical errors. How can mistakes that may endanger the health of human beings ever be regarded as "treasures"? For physicians to adopt such an attitude seems not only unethical but also professionally dangerous given the modern malpractice climate.

Yet, on second inspection, the idea that much can be learned from medical errors appears intuitively obvious and incontrovertible. Physicians owe it to their patients and themselves to do a better job of using the science of error prevention to improve the practice of medicine in the future. To do this will require support from their patients and no small amount of courage.

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By Leonard A. Simon, Esq.

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No event is more unsettling in a hospital than the injury or death of a patient. In an effort to understand and preclude the reoccurrence of unfortunate events, the peer review process was established.

Often, the only documentation that exists of an untoward event is the official hospital record. Because the record may have been created by the very individuals responsible for poor care, it may not be wholly accurate or complete. Given this, a hospital's quality control or risk management department will often conduct its own investigation as to what actually happened.

In a malpractice case, the court generally has no more information at its disposal than the hospital record. Current law, as it is interpreted, drops a veil of secrecy around the peer review process and even simple incident reports are often swept up into a broad and undefined "peer review" proceeding. This veil of secrecy bars the court from access to any peer review activities and reports by the hospital. Indeed, if there is any piece of paper generated in a hospital about a particular event, it disappears under the cover of peer review. This puts plaintiffs at an inherent disadvantage, which was never the intent of the law.

The Massachusetts Academy of Trial Lawyers is sponsoring House Bill 5216 which would remedy this significant problem by amending current law. The purpose of the bill is to provide equal access to the facts and the truth when a patient has been injured or has died in a questionable event occurring in a hospital setting.

We are not seeking to infringe on the peer review process because we are not asking for the conclusions of the reviewers. But by the same token, peer review should not be used as a guise to hide information which a patient has the right to know.

Specifically, the bill gives the courts the power to order that underlying factual information and documentation shall be discoverable but that the opinions rendered by persons testifying at the medical peer review committee and the conclusions of the committee shall not be discoverable.

In short, the purpose of the bill is to open up the results of the information gathering process. This is critically important for several reasons. First, the injured patient, more than anyone else, should have a right to know what has been found out about the care

that he or she has been given. (The fact that there are circumstances which could give rise to a legitimate question of liability is no reason to sequester important information. Quite to the contrary, it is precisely why the information should be available.) Second, those who may be responsible for the injury would have the exclusive access to the information and might well use it to their advantage in a court of law.

This, obviously, creates an uneven playing field. Third, if a hospital investigation is undertaken under the label of "peer review," any information -- even an undisputed fact -- is prevented from being discovered. There may be division of opinion as to whether the care rendered was appropriate or not, but cloaking in secrecy the facts of an incident is unfair, and it is not what the law was intended to do.

Another purpose of the statute is to give some definition to what a peer review committee or process is, so that there is not a broad swipe of "peer review" stamped on any investigation conducted by a hospital, which is what now sometimes occurs. What we're really asking for, you could say, is truth in advertising.

It has been suggested that the bill could serve to intimidate physicians appearing before a peer review committee, fearing that what they say could end up before the courts. For individuals who would be called to give information, they should be willing to give the information as objectively as they can. For most individuals, it would not chill their objectiveness in providing an account of what happened. What we're seeking are the facts of what occurred, not the conclusions of their critical thinking of what was done or not done and whether it was appropriate. That would still remain very much protected under what we're suggesting. The bill simply allows the patient to present to the court to have the same factual foundation upon which to draw their own conclusions. This would be accomplished without even knowing the result of the in-house, professional committee. In short, there should be no reason why anyone should feel concerned about making a statement because their critical views would not be discoverable.

Indeed, there are multiple safeguards built into not only current law, but HB 5216, for both the physicians being investigated as well as the reviewers. Most important is that the bill, as drafted, does not give immediate access to a party seeking the documents. It only provides a mechanism for a judge to look at the documents and make an appropriate determination. Even then, there are protections in place to prevent improper or unauthorized use of any information which may be contained in those documents. For example, the bill provides that certain documents can only be

obtained upon showing that there is a "substantial need for that information and whether that party is unable without undue hardship to obtain the substantial equivalent of the information through other means."

Many of the goals of physicians and attorneys are the same. While malpractice and peer review are contentious subjects which have, and are likely to continue, to divide the professions, I think careful consideration of the peer review process, as the law is now implemented, will show the undisputed need for reform.

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Discovering Psychological Records in Personal Injury Cases

CHERI L. CROW, ESQ.

In 1968, the Massachusetts Legislature enacted a statutory privilege protecting from disclosure the communications between a patient and a psychotherapist relating to the diagnosis or treatment of the patient's mental or emotional condition. G.L.M. c.233, §20B. This privilege belongs to the patient but it does not apply in certain circumstances. *Id.* One exception to the application of the privilege is "[i]n any proceeding, except one involving child custody, in which the patient introduces his mental or emotional condition as an element of his claim or defense, and the judge or presiding officer finds that it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychotherapist be protected." G.L.M. c.233, §20B(c).

There have been no reported cases interpreting this statutory privilege or its exceptions in relation to personal injury lawsuits. It is to be expected that this privilege and exception would be at issue in personal injury cases in which the plaintiff has brought a claim for either intentional or negligent infliction of emotional distress or he has brought a claim for which he seeks damages for his alleged mental suffering. A defendant might seek to argue that plaintiff's emotional distress or mental suffering was not caused by the incident at issue in the lawsuit.

Although there are no cases on this issue, it appears from the wording of the statute that the exception will not apply to personal injury cases in which the defendant seeks to place the plaintiff's mental or emotional condition at issue.

When the parties dispute the discoverability of one party's records relating to the diagnosis or treatment of a patient's mental or emotional condition, the matter will have to be resolved by the court. Guidance in determining the approach that can be expected (and sought) when the court addresses the issue as to when the privilege or its exception shall prevail in personal injury suits may be found in a recent case analyzing the privilege in a criminal case.

In August, the Massachusetts Supreme Judicial Court decided *Commonwealth v. Bishop*, 416 Mass. 169 (1993). *Bishop* addressed the constitutional standard to determine when disclosure of statutorily privileged records is required to provide a criminal defendant a fair trial. *Id.* at 177. In *Bishop*, the defendant, a scoutmaster, was found guilty of having unlawful sexual intercourse with two children under the age of 16, brothers who were members of the troop. *Id.* at 173. On appeal, defendant asserted that the motion judge erred, *inter alia*, in refusing to disclose to him certain psychological and medical records of the brothers. *Id.* at 174. The court specifically noted that certain of the records sought were privileged pursuant to G.L.M. c.233, §20B. *Id.* at 174 n.2.

The *Bishop* court established a five-stage procedure for trial judges to follow in determining whether the privilege should be pierced. With some adaptations, it appears that this procedure should be useful in determining when the privilege will prevail and when the §20B(c) exception will prevail in a personal injury lawsuit.

As applied in the criminal context, the stages are as follows:

Stage 1 — The judge decides whether the records sought are privileged.

Stage 2 — If privileged, defense counsel must submit the theories under which the records sought are likely to be relevant to an issue in the case. Access to the documents is denied if the judge decides they are not likely to be relevant. If the judge decides they are likely to be relevant, then he shall review them *in camera* and determine whether the records, or any portion of them, are relevant.

Stage 3 — Subject to a protective order preventing disclosure, defense counsel and the prosecutor are given access to the relevant portions of the records for the sole purpose of determining whether disclosure to the fact finder is required to provide defendant a fair trial.

Stage 4 — If, after written motions (and an *in camera* hearing if desired by the judge), defendant meets his burden of demonstrating that disclosure to fact

This article is reprinted with permission from the **Civil Litigation Section News**, *September 1993. Cheri L. Crow is a solo practitioner in Reading, specializing in employment law.*

that is required to provide him a fair trial, then the judge shall permit disclosure conditioned on appropriate terms and conditions.

Stage 5 — In a voir dire examination, the judge shall determine the admissibility of the records counsel seeks to introduce into evidence.

In a personal injury case, the issue of whether documents are privileged under G.L.M. c.233, §20B or discoverable under the exception contained in §20B(c) will usually be raised in a motion to compel production. At that time the judge should first decide whether the records sought are privileged under the statute. If the documents are determined to be privileged, then the moving party should submit the theories under which he contends the §20B(c) exception applies. In other words, all bases for the position that the patient has introduced his mental or emotional condition as an element of his claim or defense should be set forth. In *Petition of Department of Social Services to Dispense with Consent to Adoption*, the court ruled the §20B(c) exception inapplicable because the *mother* had not introduced her mental or emotional condition on the merits of the petition; it was the department which did so by alleging her unfitness in its petition. 396 Mass. 485, 487 n.4 (1986). Thus, where the non-patient party introduces the issue it appears that the §20B(c) exception will not apply.

In addition, the moving party should present the reasons why the records sought are likely to be relevant to an issue in the case. If the judge is not persuaded that the patient has introduced his condition as an element of the case or that the records are likely to be relevant, then the judge should deny the motion and proceed no further. On the other hand, if the judge is persuaded that the patient has introduced his mental or emotional condition as an element of his claim or defense and that the records are likely to be relevant, then he shall review the records *in camera*.

At this time, the judge should determine whether the records are relevant to any claim or defense of the patient. Relevancy is the standard that should be used since Rule 26(b)(1) of the Massachusetts Rules of Civil Procedure provides, in pertinent part, that "[p]arties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party." If the judge determines that the records are not relevant, then he should deny the motion to compel.

If the judge deems them relevant, then he must next determine whether it is more important to the interests of justice that the communication be disclosed than that the relationship between patient and psychotherapist be protected.[1] *See Commonwealth v. Trapp*, 396 Mass. 202, 212-213 n.10 (1985)(judge made requisite finding that the interests of justice required that defendant's communication be disclosed since defendant had introduced his mental condition as an element of his defense). If the judge determines that it is more important to protect the psychotherapist-patient relationship, then he should deny the motion setting forth his reasons in writing. If the judge determines that the interests of justice require that the records be disclosed, then he should allow the motion to compel setting forth his reasons in writing. The disclosure should be conditioned on appropriate terms and conditions limiting disclosure. Often, in situations involving information or documents of a confidential nature, the court (or the parties themselves) will condition disclosure to limited persons and uses.

At trial, the admissibility of the communications/records should be determined in a voir dire examination.

Conclusion

The *Bishop* case may provide some guidance to parties seeking to either obtain or prevent the disclosure of psychological records in a personal injury case. ❧

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1. It is conceivable that in some cases, the court would allow the parties to examine the relevant portions of the records for the sole purpose of providing input on the issue of whether it is more important to the interests of justice that the communication be disclosed or that the relationship between patient and psychotherapist be protected. Such an examination would be subject to a protective order to ensure the information was not divulged beyond the extent required.

An argument could be made, however, that such a procedure should not be allowed because such disclosure, even if for a limited purpose, is protected by the statute unless and until the judge decides that it is more important to the interests of justice that the communication be disclosed.

TESTIMONY TO THE ADVISORY COMMITTEE ON
PUBLIC DISCLOSURE OF PHYSICIAN INFORMATION
FEBRUARY 2, 1995

Judge Kramer, Professor Miller, Dr. Lazare.

Good morning, my name is Elliot M. Stone and I am the Executive Director of the Massachusetts Health Data Consortium. The Consortium is a non-profit "broker" of information products and services to support health policy development. Since 1978, we have created many new healthcare data bases, including providing technical assistance to the Board of Registration in Medicine (BRM) when it designed its first database on desktop computers and to the Massachusetts Medical Society for its recent studies using the Board's data to report on Physician Supply in Massachusetts.

Thank you for this opportunity to present my views to your Advisory Committee. This testimony represents only my opinion and does not necessarily reflect the position of the Massachusetts Health Data Consortium Board of Directors nor our member organizations.

This morning I would like to comment on the extent to which the public should have access to the bank of information held by the Board of Registration in Medicine. The Consortium staff's comments reflect the needs of our member organizations and a constituency of over two hundred eighty (280) clients/data users who have been asking the Consortium for physician profiles. Traditional users include hospital planners, managed care staff at insurers, government policymakers, physician groups and health services researchers who are designing outcomes studies. New users include corporate benefit managers, community health centers and VNAs. This broad constituency of users need timely, complete, accurate, uniform and comparable data.

On the subject of uniformity and comparability, this Advisory Committee and the Board of Medicine face the same dilemma -- how to take data submitted from thousands of sources and standardize them into useable indicators. On the subject of completeness and accuracy, the

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Consortium staff knows from cooperating with the Board of Medicine and examining its public use files that there is still incorrect information even in the mundane, but frequently used, data elements such as zip codes (approximately 800 records - less than 5% of the file need to be reviewed and corrected), but we would expect similar problems once the more sensitive, but less frequently used, data elements (such as malpractice data) are examined and validated.

First, congratulations to the Secretary of Consumer Affairs for convening this Advisory Committee. I strongly support the efforts of the Secretary and this committee to propose changes in policy which will make data on physician practices more publicly available. The question that the Massachusetts Health Data Consortium has addressed over the last seventeen years is: who is the "public" that will benefit most from the availability of these data?

Your Advisory Committee will benefit from considerable activity on this subject, which is occurring both locally and nationally regarding what information consumers need and/or want. The National Committee for Quality Assurance (NCQA) has conducted consumer focus groups, the New England HEDIS Coalition convened a local focus group prior to the release of its Baseline Performance Profile of HMOs, and the Massachusetts Group Insurance Commission recently received over 3,000 surveys from state employees during their annual health plan enrollment period.

In each of these efforts, one of the first issues is: who is the consumer? Currently, many employers may decide to limit the number of health plans and their corresponding physician networks which are offered to their employees. In that context, the benefits manager of the corporation is the "consumer" of information, making judgements with regard to physician networks.

The Group Insurance Commission asked the state employees to rate from "not useful at all" to "essential" thirteen types of information to help them choose a health plan. Of these thirteen items of information, only five were rated as "essential" by a majority of state employees. One of those essential items was: *information about the quality of primary care physicians*. In this

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context, state employees were "consumers" of information to help them choose from among the plans pre-selected by the Group Insurance Commission.

When the New England HEDIS Coalition convened its focus group of benefits managers, they discovered that these managers were planning to use the Baseline Performance Profiles as an indicator of each HMO's level of activity and aggressiveness in monitoring the providers in their networks. However, these benefits managers agreed that they needed considerable training to understand the significance of the measures that the health plans selected and why they were selected as comparative measures: such as the significance of cholesterol screening rates and/or asthma readmission ratios. These benefits managers also revealed great skepticism over any data which were self-reported by the health plans.

The National Association of Health Data Organizations (NAHDO) is also tracking "report card" activities in other states, such as: the coronary bypass surgery by hospital and surgeon (New York state (improved mortality rates in New York) and Pennsylvania). These states are finding that the principal consumers of the "report card" are hospitals, health plans and physician groups.

Your Advisory Committee could also be guided by the Massachusetts Rate Setting Commission which has developed different levels of public access to data which identify patients and physicians.

The basic premise of my testimony is that the "public" is best served when physician groups, practice administrators and medical directors of health plans have open access to the type of information held by the Board of Registration in Medicine. These professionals would be the first to admit that much of their information about physicians is anecdotal.

Currently, most knowledgeable professionals in the healthcare field choose their primary care physician and/or specialist by asking other physicians, nurses or healthcare professionals. In order to improve this process, I believe that: (1) primary care physicians need to know as much

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as possible about the physicians to whom they refer their patients: (2) the great majority of the public will continue to ask their friends, relatives and (hopefully) their physicians about who to select for their medical care. Most of the general public will not use publications listing "the best" doctors or "the best" hospitals; (3) the general public should have confidence that physicians listed in the directories of managed healthcare plans have been thoroughly screened by those organizations.

On the questionnaire, prepared by the Advisory Committee on Public Disclosure of Physician Information, I could not answer "yes" or "no" for many of the data elements because my answer for most of the categorical groupings of information would have been "it depends on who needs to know".

I would like to recommend that the Board of Registration in Medicine start now to convene a series of pilot demonstration projects in the use of any information in the Board's files, including medical malpractice claims and disciplinary action. Examples of approved applications for controlled studies might include:

- Pilot Application #1: A private sector managed care organization for credentialling new physicians in a network

- Pilot Application #2: A hospital and/or community health center for credentialling new members for its staff

- Pilot Application #3: A large multi-specialty practice to review each physician's files and prepare profiles

- Pilot Application #4: A primary care group to profile physicians to whom they refer patients

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- Pilot Application #5: A utilization review and/or peer review organization to profile their physician reviewers

- Pilot Application #6: Medicaid for credentialling its physician network

- Pilot Application #7: A physician specialty society to profile a group of their colleagues
  - for example, Massachusetts Orthopedic Society might want to create an ad-hoc working group to examine the Board's information for some of its members' practices which are adding surgeons.

- Pilot Application #8: A consumer advocacy group to profile physicians for a specific subject

I would recommend that the Board of Registration in Medicine use a practical demonstration project phase before it tries to answer the question abstractly of what information ought to be routinely disseminated publicly for hypothetical applications.

Each demonstration project could be required to answer the following questions as a condition of receiving full access to the Board of Registration information: (1) Which data elements were most useful in profiling the physicians in your pilot project? (2) Which data elements were least useful? Could these data elements be useful if asked differently on Board of Medicine questionnaires? Would these data elements be more useful as criteria if the data were more complete? (3) What new information should the Board request from physicians for your application? (4) What caveats would you propose for the use of each data element by the general public?

In this way, each of the 35+ elements in your survey would be examined and commented upon by a working group with a practical application.

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Each demonstration/application should require that the project manager agree to the following procedures: (1) Present its physician profile findings to the Board of Registration in Medicine; (2) Describe its methods; (3) allow identified physicians to review the accuracy of the findings, and (4) comment on the accuracy and completeness of each data element used.

Anytime that the Massachusetts Health Data Consortium has embarked on a new study to release sensitive information about hospitals, health plans or physicians, it has followed this practice of developing a series of report formats tailored to questions proposed by experts with a specific "need to know".

The Massachusetts Health Data Consortium would be pleased to formally assist this Advisory Committee and the Board of Registration in Medicine in any of its efforts to create demonstration projects using the Board's information.

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TESTIMONY OF DAVID A. SWANKIN, ESQ.
PRESIDENT, CITIZEN ADVOCACY CENTER,
TO THE ADVISORY COMMITTEE ON PUBLIC DISCLOSURE
OF PHYSICIAN INFORMATION,
THURSDAY, FEBRUARY 2, 1995
STATE HOUSE, BOSTON, MASSACHUSETTS

Members of the Committee:

I appreciate your invitation to testify on this important issue. You have been charged with a most important assignment -- to recommend to the Secretary of Consumer Affairs any legislative and policy changes necessary to assure that the Massachusetts Board of Registration in Medicine has and executes a sound, responsible, defensible program concerning public disclosure of information about licensed physicians. It is a subject that has been at the top of the Citizen Advocacy Center's (CAC) agenda since the creation of the program.[1] We staunchly advocate that boards release all information in their possession unless there is a compelling public policy reason for keeping it confidential.

Boards possess many categories of information, each of which

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[1] CAC began in 1988 as an autonomous program of the American Association of Retired Persons. By January, 1994, CAC had matured into an independent organization and was incorporated as a 501(c)(3) nonprofit, governed by its own board of directors. CAC is a unique support program for the thousands of public members who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory boards or selected by private sector institutions to sit on a board of directors or advisory panel, public members are usually in the minority and are without the resources and technical support available to their counterparts from professional and business communities. CAC was created to fill this gap by providing research, training, technical support, and networking opportunities for public members. A fact sheet explaining in greater detail the activities of CAC, including the names of the Board of Directors, is attached to this testimony.

We have produced a number of reports that deal with disclosure of information by regulatory boards, copies of which I am submitting for the record in an Appendix to this testimony. I will refer to some of these reports later in this testimony. They are:

- ☐ Release of Information to the Public by State Boards of Medicine and Nursing (April 1992)
- ☐ Public Information Programs of State Boards of Nursing -- Results of a Survey by the Citizen Advocacy Center (August 1993)
- ☐ Information Exchange Between Peer Review Organizations and Medical Licensing Boards (November 1992)
- ☐ The Use of Alternative Dispute Resolution by Health Professional Licensing Boards (November 1994)
- ☐ Medicare Peer Review Organization Outreach Programs -- Results of a Survey by the Citizen Advocacy Center (April 1993)

can be useful to consumers for different reasons. The categories include:

- Provider Specific Information

  This includes profiles of individual physicians indicating relevant vita and credentials. It also includes practice information, including disciplinary actions, malpractice claims and suits, and outcomes experience, such as mortality rates, etc.

- Board Performance Information

  This includes all relevant operating statistics showing how well and how efficiently the board is doing its job.

- General Information

  This includes consumer educational material such as what the board does, how to complain, when to complain, and how to use board information.

Your committee is concentrating on the first category (provider-specific information) but, as I will point out in this testimony, we believe all the categories are inter-related.

Your task requires you to make recommendations on:

- WHAT information to release
- WHEN to release it
- HOW to release it

Before I comment on the particulars, let me put the entire issue of disclosure of information into context. We live in an age when there is a great consensus around the proposition that informed consumers are empowered consumers, and empowered consumers are essential to a well-functioning healthcare delivery system that both optimizes quality and contains costs. There is no real debate over the need for and value of well informed consumers. Liberals and conservatives, Democrats and Republicans, consumers and providers all endorse the idea.

CAC starts from the proposition that all information in the possession of the licensing board should be considered public information, unless there is an overriding public policy reason for keeping it confidential. This same philosophy should be adopted by this committee when developing recommendations for the Secretary. You should ask:

- What information does the board possess?
- Is there any overriding public policy reason for not making it public?

The burden should rest on those who would keep information confidential, not on those who would release it.

As you will see from our responses to your questionnaire on public disclosure of physician information, we recommend that almost all of the information the Board of Registration in Medicine presently keeps confidential should be available to the public. This includes information about physicians' medical malpractice experience, disciplinary histories, criminal charges and convictions, and employment and credentialing experience. And, of course, we support continuing to release information presently considered to be public, in particular information about disciplinary activity. On this point, we congratulate the Massachusetts board for being ahead of the pack by releasing more disciplinary information and releasing it sooner than many boards do.

If the guiding principle is openness, what criteria should be used to determine those exceptional cases in which is it appropriate to keep information confidential? We think the rules of thumb can be found in Federal and state freedom of information laws enacted since the 1960s. These laws specify exemptions to protect due process and privacy rights of individuals and to assure the ability of the government to function effectively. Accordingly, they exempt investigative files, litigation strategy-planning sessions, personal medical records, and other categories of information from most freedom of information statutes.

One of the best examples of an area in which we believe a legitimate case can be made for keeping some categories of information confidential is physician impairment programs. Let me address this subject from two different points of departure.

1. THE IDENTITY OF PHYSICIANS ENROLLED IN IMPAIRMENT PROGRAMS. We have supported keeping confidential from the public, *but not from the board itself*, the names of physicians who, as an alternative to discipline, have been enrolled in state-operated or state-monitored impairment programs. We have concluded that keeping this information confidential does not violate public policy <u>provided</u> that the board has in place strong oversight programs and at a minimum can answer "yes" to the following four questions contained in the Federation of State Medical Boards' 1992 "Self Assessment Instrument for State Medical Boards:"

(1) Does the board formally approve rehabilitation programs before referring impaired licensees to them?

(2) Does the board have specific criteria that rehabilitation programs must meet to be approved?

(3) Does the board have a policy for reviewing and reapproving rehabilitation programs on a systematic basis?

(4) Is there a contractual or similar agreement for board management or oversight of a rehabilitation program or programs?

Of course, a board could answer "yes" to these four questions and still have highly questionable criteria in place. Nevertheless, these questions value board control and oversight over impairment programs.

Delving more deeply into the subject of board oversight over impairment programs, and the important matter of monitoring the compliance of individual physicians, CAC's Executive Vice President, Rebecca Cohen, and CAC Board Member, Richard Morrison, co-authored a Resource Brief entitled, "The Regulatory Management of the Impaired Practitioner." The Resource Brief was published in 1993 by the Council on Licensure, Enforcement, and Regulation (CLEAR). A copy is included in the Appendix to my testimony. In it the authors state (pages 6-7):

"The tight confidentiality assurances associated with many impairment programs raise several public policy questions, not the least of which have to do with determining whether a practitioner enrolled in an impairment program can continue to practice safety while undergoing treatment. California's Diversion Program for Impaired Physicians, for example, permits physicians enrolled for treatment to continue to practice medicine during the rehabilitative period 'when that is appropriate to their condition, and adequate safeguards for public safety can be provided.'

"That is a critical judgment call. While a board would surely want to weigh the clinical opinion of the treatment facility, the ultimate responsibility for granting or denying permission to continue to practice, and for establishing appropriate conditions and safeguards, clearly rests with the board. In this circumstance, absolute confidentiality would cripple a board's ability to meet its responsibility to protect the public health and safety. In the authors' view, cutting the board completely out of the loop goes beyond the bounds of reasonable balance of interests and objectives.

"Even when they are part of the loop, boards need to constantly remind themselves that by guaranteeing

confidentiality, they are as a matter of policy depriving the public of information that is often available for all other board interventions. Assuming that it is a justifiable policy, and recognizing that it may be the case that confidentiality is mandated by statute, guaranteeing confidentiality places a board in a posture in which it must assure itself on a case by case basis that the treatment program is proceeding in a satisfactory manner. Achieving the objectives of confidentiality from public disclosure does **not** mean a board should refrain from monitoring and making decisions about the specifics and progress of each case."

2. INFORMATION THAT MIGHT VIOLATE THE AMERICANS WITH DISABILITIES ACT (ADA). Professional licensing boards have been struggling to resolve the questions as to what information they can ask applicants for licensure and for licensure renewal without violating the ADA. At CAC, we have reported on this issue in our newsletter, ***CANews***, and our relevant articles on this subject have been included in the Appendix to this testimony.

The U.S. Department Justice has challenged questions asked by the New Jersey Board of Medicine, arguing that asking broad questions such as the following violates the ADA:

"• Have you ever been dependent on alcohol or Controlled Dangerous Substances?

• Have you ever been treated for alcohol or drug abuse?

• Have you ever suffered or been treated for any mental illness or psychiatric problems?"

The law is still unsettled in this field, but we believe that the same rule applies here as it does with board-sponsored impairment programs -- it is essential that licensing boards know the names of persons who are or have been treated for an impairment. We think that the answer lies <u>not</u> in prohibiting the boards from possessing information about treatment but rather in assuring that this information is kept confidential in appropriate circumstances.

I want to reiterate that generally we favor full disclosure, and we are concerned when we see proposals to keep information confidential in inappropriate circumstances. For example, our most recent publication, "The Use of Alternative Dispute Resolution (ADR) by Health Professional Licensing Boards" (November 1994), examined the issue of confidentiality in ADR programs. We oppose granting confidentiality to ADR programs. Writing about the mediation program being introduced by the Massachusetts Board of

Registration in Medicine, we said:

> First, there are major concerns about the program's promise of confidentiality. From the point of view of public policy, the essential question is this: Do the benefits that result from keeping mediated settlements confidential outweigh the benefits that flow from giving the public access to information that is relevant to selecting a health care provider?
>
> Many in organized medicine believe that the objective of protecting a physician from harm to his or her reputation generally outweighs the goal of giving the public access to complaints, particularly when no disciplinary action results. Most independent commentators conclude otherwise.
>
> Another argument in defense of confidentiality is that once a public action is begun, the respondent practitioner will spend whatever he or she can afford to have the complaint dismissed. The Board, in turn, must then expend its limited resources mounting a case. Thus, this line of thinking goes, it can be less expensive and faster to resolve less serious cases when they are kept confidential and the practitioner's public reputation is not at stake. If the board is responsible about maintaining records and monitoring mediations, repeat offenses should be easily detected.
>
> These arguments notwithstanding, the public's need, if not right, to know about legitimate complaints, even those alleging only *de minimis* infractions of the law or health code, needs to be protected. Before sealing off access to the complaints resolved through mediation, the need for confidentiality must be found to be both greater than the potential detriment to the public, and necessary to the success of the program.

The entire report is included in the Appendix to this testimony.

In preparing the report we posed a number of questions to Alexander Fleming, Executive Director of the Massachusetts Board of Registration in Medicine. The very first question dealt with confidentiality.

We asked:

> "If a licensee's participation in the program is kept confidential, is the public being denied access to information needed to choose many health care providers?

a. If the terms of any mediated settlement are kept confidential, how will the Board enforce such settlements?

b. How will the Board keep track of "repeat offenses?" Will the Board have the authority to impose disciplinary action on the basis of repeated attempts by incompetent physicians to hide behind mediated, non-public settlements?

c. If mediated settlements are not matters of public record, will other states be able to cross-check licensee files to determine if there is a problem of which it should be aware?

d. If mediation fails to resolve a dispute, and all of the information disclosed at the conference is kept out of official records, won't the Board be duplicating its efforts by having to reinvestigate many of the same issues?"

Mr. Fleming responded:

"The goal of the Board's Voluntary Mediation Program (VMP) is to provide a forum for the resolution of appropriate disputes between physicians and patients. A fundamental tenet of mediation is that the process be voluntary and mutually agreed upon if possible. In order to motivate the parties to participate, and in anticipation of there being no agreement at the end of the process, an agreement that the discussion in the mediation be kept confidential is essential. If, after the parties reach agreement, they agree that they may disclose the contents of the conversation, and/or the ultimate settlement, they may do so.

The policy question raised by question #1 is a good one, and an issue that the program has considered carefully, and is continuing to discuss. In our program, there are three components for which confidentiality is an issue: 1) the contents of the discussion; 2) the settlement, if any; and, 3) the actual participation of the parties in the program. The Massachusetts Board takes very seriously its responsibility to inform the public about physicians according to the law. Massachusetts goes farther in this regard than many other states in that it will consider a dismissal of a complaint to be a public record, even if the physician is completely exonerated in the process.

For the purposes of this first phase of the VMP, the

Board will select cases which have little or no disciplinary potential. That is, they would likely be dismissed ultimately. However, in order to test the motivational factor of confidentiality of the participation by the physician in the program, the Board will offer "participatory confidentiality" to half of those contacted. For the other half, the Board will inform the parties that a successfully mediated case will be carried on the public record as "successfully mediated," rather than dismissed. Thus we hope to be able to determine this important motivational factor without compromising the public's access to meaningful information.

a. The terms of any mediated settlement will be known to the Board and, depending upon the terms of the settlement, the Board will participate in the enforcement.

b. The Board will track the results of all mediated settlements, and will guard against the improper use of this vehicle.

c. See #1, above.

d. Yes. We believe that the benefits of this process will outweigh any duplication."

CAC has encouraged boards not only to think of confidentiality as an exception to the general rule of open access, but also to make information available in a pro-active manner. In our 1993 report entitled, "Public Information Programs of State Boards of Nursing" (full text is in the Appendix to this testimony), we said:

> "Since its inception, CAC has encouraged and helped public members find ways to make their boards more accountable to the public. Perhaps the most important way to be accountable is to publicly disclose information documenting board performance. CAC has urged all board members to ask themselves if they are satisfied that their board's information disclosure is thorough enough to keep the public informed and to enable outsiders to evaluate overall board performance."

In that study, we found the boards to be refreshingly open with regard to making information available on request, but not very good at taking affirmative action to make information available on their own initiative. Our key finding reads:

> "Boards of nursing make significant amounts of information available to the public, covering the following eight program areas:

I. General Information
II. Budget
III. Census Information
IV. Testing Data
V. Licensure Activity
VI. Disciplinary Activity
VII. Penalties/Corrective Actions
VIII. Legislative Activities

Boards, however, are not particularly proactive about disseminating this information. Responses such as "board meetings are open to the public," "minutes of meetings are published," and "available upon request," point to the fact that it is up to interested citizens to seek out information concerning the board's activities. Though they have such information available, boards rarely take the initiative to see that it gets into public hands.

Contrast that with the outreach programs of the Medicare Peer Review Organizations (PROs). In our 1993 study on that subject, "Medicare Peer Review Organization Outreach Programs -- Results of a Survey by the Citizen Advocacy Center" (full text is included in the Appendix to this testimony) we found:

- All thirty-five respondents reported having a printed brochure and/or pamphlet.

- Twenty-three of the thirty-four respondents reported explaining operating statistical categories in simple language.

- Most of the PROs indicated that the most widely used, and most effective venue for holding outreach programs, cited by all thirty-four of those respondents holding programs, is senior centers.

- Eleven of the thirty-four respondents reported using a slide show in outreach presentations. Sixteen reported using a video tape in presentations.

- Thirty-two respondents have a Speakers Bureau. Twenty-nine reported using outreach staff for their Speakers Bureaus. Twenty-five respondents use other PRO staff as speakers and twenty-four use medical directors.

- All respondents reported having an 800-hotline. The most common method of advertising the hotline is through outreach presentations. The respondents selected outreach presentations as the most effective way to advertise hotlines.

- Twenty of the thirty-four respondents [Nebraska did not answer] have a Citizen Advisory Committee, most of which meet quarterly.

- Twenty-seven of the thirty-five respondents reported participating in a public information program on television or radio.

- Twenty-four of the thirty-five respondents reported having a prepared Public Service Announcement.

- Nineteen of the thirty-five respondents were featured in a newspaper article within the last twelve months.

- Nineteen of the thirty-five respondents reported having a method for evaluating outreach effectiveness.

- Twenty-three respondents reported an outreach budget between $5,000-$50,000.

The Massachusetts Board of Registration in Medicine should adopt as part of its mission statement a goal of becoming recognized throughout the state as a consumer protection agency. In many states, including Massachusetts, certain agencies have operated in a manner to earn that reputation. Offices of the Attorney General come to mind as the best example of that idea. Since the mission of the board of medicine is to protect the public health and safety, the two concepts are totally compatible.

Last December, two major national consumer organizations -- the Consumer Federation of America and the American Association of Retired Persons -- held a joint press conference criticizing state real estate licensing boards for failing "to adequately represent, educate, and protect home buyers and sellers." They recommended that consumer education be given a higher priority than it currently receives. I believe many consumer advocacy groups would make the same case in connection with health licensing boards.

Much of the information the public may wish to have made available is information generated by the Board of Registration in Medicine itself. Other information is generated elsewhere and reported to the board, usually because of a statutory or regulatory requirement. This latter category includes malpractice information (generated by insurers, courts, and others) and provider institution adverse actions (adverse actions by hospitals, for example). How the board views its responsibility to release information generated by others will very much depend on how it views its overall mission as a consumer information and protection agency.

Ask yourself this question: Should the residents of Massachusetts have a right to expect their State Board of Registration in Medicine to be an agency that protects their health and safety by acting as both an enforcement agency and an information agency? Should they be able to look to the board not only as a place to lodge a complaint when they have a bad experience with a physician, but also as a place to assist them in choosing among health care providers and otherwise navigating the health care delivery system? I strongly believe they should be able to look to the agency for both.

If you agree, then you will have a framework for deciding the three questions I raised earlier -- questions you have to answer:

- WHAT information should be released
- WHEN should it be released
- HOW should it be released

Q. WHAT SHOULD BE RELEASED

Please refer to the completed questionnaire you asked me to fill out which is attached to this testimony.

Q. WHEN SHOULD INFORMATION BE RELEASED

Disciplinary Information

Massachusetts is one of the states that releases information to the public at the time the board has enough evidence to go forward with a proceeding. That is the policy CAC endorses. As you know, some states keep disciplinary information confidential until there has been an admission or finding of violation. That deprives the public of timely access to important information about physicians who are awaiting resolution of the charges against them. We urge this committee to endorse the current policy.

You should also endorse the current Massachusetts policy of making public information that a complaint has been dismissed, even if the physician is completely exonerated in the process.

Q. HOW TO RELEASE INFORMATION

The Board should develop a comprehensive pro-active information program, that would include news releases, physician profiles, and special reports for various types of data. The program should have one component that involves direct distribution to consumers, including an 800-number, brochures, print-outs of physician profiles, etc. A second program component should be designed to encourage the media to report on the board's

activities. A third program component should be designed to assist third parties to develop useful consumer information.

Consumers Union, the Center for the Study of Services, and Health Pages magazine are all good examples of independent, third party institutions expert at disseminating complicated information in a user-friendly manner. I have included a copy of the Fall/Winter 1994 issue of Health Pages in the Appendix to my testimony, since it includes detailed, provider-specific information on Boston and Worcester doctors, hospitals, and insurance plans. I call your attention to page 31 of that issue of Health Pages, where there is only a passing reference to the Massachusetts Board of Registration in Medicine. That is a lost opportunity.

Before closing, let me say a word about what almost always is raised by those who would hold back information on the grounds that "consumers won't understand it" or "consumers will be misled by it." In a great many cases, that is a red herring. Certainly some of the information you are considering for disclosure needs explanation to be properly understood. I have in mind institutional or provider mortality rates, for example. The Federal Health Care Financing Administration (HCFA), for example, has devoted much time and many resources to develop meaningful data on hospital mortality rates. When they release that information, they offer each hospital an opportunity to explain its view of the published rate, and that explanation is always included when rate information is released.

But most of the information you are considering does not fit that category. Consumers, the media, and third party information disseminators are smart enough to deal with information about their physicians that simply reports:

- Have they settled malpractice lawsuits? How many? For how much?
- Have they had judgments imposed for malpractice? How many times? What amount of damages?
- Have they had hospital privileges denied, revoked, or limited? From which hospitals? When? For how long? Why?
- Have they been convicted in a criminal court? For what offense(s)?
- Have they had their board certification, if any, rescinded? Why?
- Where did they go to school?

- Where were their residencies?

- Have they been disciplined by the licensing board? For what offenses?

- Have they voluntarily surrendered their license? For what reason(s)?

- Have they been dropped from an impairment program? When?

Last December, I saw a press release (copy attached in the Appendix to this testimony) issued by the Massachusetts Medical Society, announcing the introduction of a comprehensive bill concerning public release of physician-specific information. On pages 6-8 of the medical society's bill, twelve requirements are spelled out for every situation where information is collected or reports compiled "intended to compare individual health care providers." I submit to you that for virtually all of the categories of information you are considering (as indicated by the types specified on your questionnaire), these twelve guidelines are unnecessary, and would in effect put a damper on the release of any information.

On pages 3-4 of their bill, the medical society lists 18 categories of physician-specific information that should be compiled and released. For the first five categories, the medical society's bill would entitle every physician "to provide a statement of explanation that will accompany that information upon release to a member of the public." These categories are:

(a) description of any criminal convictions, other than minor traffic offenses;

(b) description of any final and pending board disciplinary actions;

(c) description of final and, if available, pending disciplinary actions by licensing boards in other states;

(d) description of revocation or involuntary restriction of hospital privileges that have been voted on by the hospitals' governing body;

(e) indication of whether the licensee's malpractice claims history exceeds the expected norm for the licensee's specialty. This determination shall be based on assessments that are clinically and statistically valid. The board shall, in consultation with the Massachusetts Medical Society, professional liability insurers, and

consumers, develop a plan for the evaluation and release of such clinically and statistically valid claim data.

The medical society's suggestion is overkill. It would thwart the program. For the board to be required to give a physician an opportunity to present his or her side explaining away a criminal conviction, or a board disciplinary action, or revocation of hospital privileges, would tie up the board in paperwork. In this day and age of due process protections, the acts of the courts, the medical board, and the hospitals speak for themselves.

In fact, the entire draft bill seems to me to be an effort by the medical society to take over the functions of the medical board itself. It goes well beyond information disclosure. The section calling for a six person clinical quality improvement unit, four members of which would be nominees of the medical society, is a case in point. This clinical quality improvement unit would virtually take over the functions of the licensing board in dealing with substandard care cases. We've spent two decades removing state medical licensing boards from the direct control of state medical societies, and this bill would reverse that trend in no uncertain terms.

Let me conclude by reiterating CAC's position that the Board of Registration in Medicine should adopt the policy that all the information in its possession should be public information unless there is an overriding public policy reason for keeping it confidential. We believe the public has a right to information that is pertinent to their choice of health care providers and that they are capable of interpreting and applying that information. In the policy you recommend, the bias should be toward openness and the burden should rest on those who would keep information secret.

Thank you for the opportunity to present our views.

Massachusetts Advisory Committee on Public Disclosure of Physician Information

Questionnaire

David Swankin
Name
Citizen Advocacy Center
Organization

The following is a categorical grouping of information that the Massachusetts Board of Registration in Medicine collects which currently is kept confidential. Please comment on the items of information you believe should or should not be disclosed to the public. Feel free to check the items listed below, and/or provide general comments about each category. Also, feel free to comment on the manner in which such information should be released (e.g., released with comparative norms, doctors' rights to comment prior to release, etc.). Please attach additional pages as needed.

Medical Malpractice	Y	N
• record of medical malpractice claims - pending	X*	
• record of medical malpractice claims - settled (no lawsuit)	X	
• record of medical malpractice claims - suits filed	X*	
• record of medical malpractice claims - suits settled	X	
• record of medical malpractice claims - suits adjudicated (for claimant)	X	

Comments:

* - In releasing the information, it should be accompanied by a board-developed notice that would inform the public that claims pending and suits filed are different than claims and suits settled or adjudicated.

1/20/95

Disciplinary Charges & Actions	Y	N
• disciplinary charges by governmental entity	X	
• disciplinary charges by hospital, health care/professional group	X	
• disciplinary actions taken by governmental entity	X	
• disciplinary actions taken by hospital, health care/professional group	X	
• called before or warned by state or federal agency re drug privileges	X	

Comments:

1/20/95

Criminal Charges & Convictions	Y	N
• pending criminal charges	X	
• findings short of conviction (e.g., *nolo contendere*, or findings of sufficient facts of guilt without formally entering a guilty finding)	X	
• convictions related to the practice of medicine only		
• all convictions (except minor traffic offenses)	X	

Comments:

Medical Education & Post-Graduate Training	Y	N
• accusation of cheating and/or improper conduct during an exam		X**
• disciplinary action at academic institution		X**
• State and National Boards exam scores		X**
• failure on a licensing exam		X**
• non-completion of residency training program		X**
• professional evaluations		X**

Comments:

** - The medical board is charged with the duty of examining the entire record of prospective candidates. It is an unnecessary invasion of privacy to make public information surrounding training before licensing. Post-licensing experience (next category, next page) should be public.

1/20/95

Employment/Credentialing	Y	N
• withdrawal of application for medical license		X
• voluntary surrender of medical license	X	
• denial of medical license for any reason		X
• denial of recertification by specialty boards	X	
• loss of American Specialty Board Certification	X	
• withdrawal of application for hospital privileges or appointment	X	
• resignation from a medical staff in lieu of disciplinary action	X	
• voluntary modification or limitation of scope of practice for reason other than medical condition	X	
• dissolution of professional corporations if related to competence or complaint or allegation re violation of the law	X	
• restrictions on or denial of third party payor participation or enrollment	X	
• reports by peers		X

Comments:

All of the information in this category should be available except as follows:

- Withdrawal of application for medical license, and denial of medical license for any reason, results in an individual being not licensed to practice medicine. Therefore, no information about such individual need be released to the public, since they cannot practice.

- Results of peer review need to be disclosed, not the minutes of peer review activities. Similarly, reports by peers to the licensing board should be confidential. If they lead to the opening of a disciplinary action, the fact of a disciplinary proceeding is and should be public.

1/20/95

Physician Health Issues	Y	N
• emotional disturbance, mental illness, organic illness which has impaired ability to practice medicine or function as a medical student (within last 5 years)	_____	_____
• diagnosed with or have medical condition which limits or impairs ability to practice medicine	_____	_____
• use of any chemical substance which in any way interfered with ability to practice medicine (within last 5 years)	_____	_____
• alcohol or other drug dependency (within last 3 years)	_____	_____

Comments:

See testimony. Generally, the board should keep private any information it receives on its original applications, and on its renewal applications, dealing with physical and mental conditions and treatment.

In those cases where the board has proceeded to investigate a physician and has allowed a physician to enter a board-approved impairment program in lieu of discipline, then the confidentiality should be conditioned on continuing participation and successful completion of the program. If a physician has been disciplined for substance abuse, or elapses from an impairment program, this information would be made public as a disciplinary action.

1/20/95

General Questions

1. Should some form of the following information (which is not now collected) be collected and made available to the public?

   a. Mortality rates for individual physicians, e.g., rates of death per 100 for a particular procedure or surgery?

   b. Complication rates for individual physicians for a particular procedure or surgery?

   If so, should this information, when released, be compared to some accepted norm or risk rate? Other conditions on release?

Comments:

This would be very useful information. I believe New York or Pennsylvania has had experience with this, and may be able to advise on costs.

2. Should the Board develop and release a "physician profile" on each licensed physician based on the information it is empowered to collect?

Comments:

Yes. See Health Pages, Boston, pages 55-64.

Citizen Advocacy Center

A Training, Research, and Support Network for Public Members of Health Care Regulatory and Governing Boards

FACT SHEET

The Citizen Advocacy Center (CAC) is a unique support program for the thousands of **public members** who serve on health care regulatory boards and governing bodies as representatives of the consumer interest. Whether appointed by governors to serve on regulatory boards or selected by private sector institutions to sit on a board of directors or advisory panel, public members are usually in the minority and are without the resources and technical support available to their counterparts from professional and business communities. **CAC** was created to fill this gap by providing research, training, technical support, and networking opportunities for public members.

CAC's goal is to equip public members to be advocates for excellence – to continually press their boards to serve public policy goals more effectively and efficiently. To this end, **CAC** disseminates information and provides forums for the examination of public policy affecting health care delivery and regulation. **CAC** distributes a quarterly publication entitled ***Citizen Advocacy News***, produces research reports on topics of current and practical concern to regulatory and governing boards, holds an annual conference, and conducts training seminars for individual states, regulatory bodies, and others.

While **CAC** was created to maximize the leverage of public members, it does not attempt to drive a wedge between them and professional members. Instead, **CAC**'s services and publications are available to and valued by professional members of regulatory and governing boards and the executives and attorneys who staff these institutions. **CAC** has been commended for avoiding propaganda and partisan politics in its examination of issues and for not casting public members in an adversarial role *vis a vis* their professional counterparts.

The Chairman of the **CAC** Board is **Dr. Benjamin Shimberg, PhD**, a distinguished scholar in the field of professional regulation. The other members of **CAC**'s Board of Directors are people of diverse backgrounds, all of whom have substantial experience in licensure, regulation, and governance in the health care field. In addition, **CAC** has assembled panels of experts who have generously agreed to provide CAC with advice and counsel.

CAC is the proud recipient of three major awards. In 1993, **CAC** was honored by the Council on Licensure, Enforcement and Regulation with the **CLEAR Program Award**. Also in 1993, the **Administrators in Medicine of the Federation of State Medical Boards** presented its **Executive Director's Award** to **CAC** for "outstanding service in the protection of the public through the promotion of effective Medical Boards and in supporting the principles of the Federation of State Medical Boards." In 1994, **CAC** received the **Health Care Financing Administration's Beneficiary Services Certificate of Merit**.

[over]

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Andrew Webber, Executive Vice President, American Medical Peer Review Association

Mark Yessian, Inspector General for Region I, U.S. Dept. of Health and Human Services

APPENDIX TO
TESTIMONY OF DAVID A. SWANKIN, ESQ.
PRESIDENT, CITIZEN ADVOCACY CENTER,
TO THE ADVISORY COMMITTEE ON PUBLIC DISCLOSURE
OF PHYSICIAN INFORMATION,
THURSDAY, FEBRUARY 2, 1995
STATE HOUSE, BOSTON, MASSACHUSETTS

1. Release of Information to the Public by State Boards of Medicine and Nursing (April 1992)

2. Public Information Programs of State Boards of Nursing -- Results of a Survey by the Citizen Advocacy Center (August 1993)

3. Information Exchange Between Peer Review Organizations and Medical Licensing Boards (November 1992)

4. The Use of Alternative Dispute Resolution by Health Professional Licensing Boards (November 1994)

5. Medicare Peer Review Organization Outreach Programs -- Results of a Survey by the Citizen Advocacy Center (April 1993)

6. "The Regulatory Management of the Impaired Practitioner"

7. Relevant *CANews*

   - Volume Five, Number Two - Medical (pages 6-8)
   - Volume Five, Number Four - Generic (pages 6-8)
   - Volume Six, Number Three - Generic (In-Depth)

8. The Fall/Winter 1994 issue of Health Pages

9. Massachusetts Medical Society press release and comprehensive bill entitled, "An Act to Increase Public Access to Data Concerning Physicians and Create a Clinical Quality Improvement Unit at the Board of Registration in Medicine"

Testimony of Steffie Woolhandler
Associate Professor of Medicine
Harvard Medical School
The Cambridge Hospital
(Testimony prepared in collaboration
with Dr. Sidney M. Wolfe,
Public Citizen Health Research Group)

We support full public disclosure of any physician specific information which has been found to be true through a reasonable due process. By this we mean that all actions by hospitals, specialty boards, or licensing agencies; all malpractice claims settled or adjudicated for the plaintiff; all criminal convictions, and all findings related to cheating, failure of Board exams, or failure to complete training.

The public has the right to know such information, and their right to know overrides the small but real risk of harm to competent, innocent individual physicians.

In my experience with credentialling at Cambridge Hospital, such harm might occur most often in 2 scenarios. Because our hospital attracts many physicians interested in human rights, we commonly train young physicians who have worked in prisons. Among such physicians, a history of frequent malpractice claims and occasional settlements, is the rule rather than the exception. This is true even for physicians whom we later find to be, through 2 or more years or observation, excellent clinicians.

The second potential area of harm to innocent, competent physicians comes when malpractice insurers settle

claims without the physician's consent. While the insurer often makes such settlements because they believe the physician to be guilty of malpractice, insurers at least occasionally settle the claim simply because it was cheaper to settle than to litigate. The potential harm to innocent physicians might be minimized by making the physician's statement regarding settlements part of the permanent disclosable record.

Despite these two potential arenas for harm to innocent physicians, we believe they are outweighed by the potential harm to patients from failure to disclose. Perhaps more sunlight on both prison health care and our tort system can move us toward improving the quality of both.

The State of Massachusetts is 45th of the 50 states in the number of disciplinary actions per thousand practitioners (1.85). Thus, it is insufficient merely to disclose disciplinary actions. The Board needs to be more vigorous in investigating and uncovering problems in the quality of physician practice.

As physicians, we enjoy the great privilege of being able to practice medicine, of being able to help others. But we also assume an obligation to maintain our knowledge, competency and vigilance for the patient's safety, and to assure that other physicians do as well. We embrace public disclosure of physician information as part of that obligation.

Submitted February 2, 1995

TESTIMONY OF

MARK R. YESSIAN, PH.D.
REGIONAL INSPECTOR GENERAL FOR EVALUATION AND INSPECTIONS
OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
BOSTON, MA

before the

MASSACHUSETTS ADVISORY COMMITTEE ON
PUBLIC DISCLOSURE OF PHYSICIAN INFORMATION

FEBRUARY 2, 1995

The views expressed in this testimony are those of the author. They do not necessarily represent the views of the Office of Inspector General or the Department of Health and Human Services.

INTRODUCTION

My staff and I conduct national evaluations of health and human services programs. Over the past decade, many of our evaluations have examined the performance of state boards responsible for the licensure and discipline of health care professionals. Even though these state boards are not federally-funded, we have focused on them because they provide an important front line of protection for individuals receiving care under the Medicare and Medicaid programs.

In this testimony, I draw on the work and insights that come from our prior work. However, I speak as an individual. The views I express are my own. They do not necessarily represent those of the Office of Inspector General or the Department of Health and Human services.

Briefly stated, I direct my testimony to three basic points. The first is that there are fundamental forces compelling medical boards and medical practice in general to become more accountable to the public. The second is that decisions about public disclosure should be consistent with these forces. In that regard, I offer three working principles. Finally, given the central responsibility of the medical board to protect the public, I urge more and better disclosure about how the board itself is performing.

THE CONTEXT

The Self-Regulation Model of Professional Regulation

For more than a century, the licensure and discipline of physicians, and other health care professionals, has been carried out under what has essentially been a form of self-regulation. Yes, the entities carrying out these functions have been part of state government, but their funding has typically been derived from licensed physicians. And their directions have been very strongly influenced by the physician community and its professional associations. As in Great Britain and other countries, the underlying norm has been that "a profession can be regulated most effectively if the regulatory mechanism is controlled by the profession itself, if it is financially independent of the state and if it has the backing of the law."[1]

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[1] A representative of the General Medical Council of the United Kingdom, the medical licensure authority of the country, offered this observation about the orientation of the Council at a recent international conference on medical licensure sponsored by the Department of Health and Human Services. See Mark R. Yessian, "From Self-Regulation to Public Protection: Medical Licensure Authorities in an Age of Rising Consumerism, Federation Bulletin: The Journal of Medical Licensure and Discipline, Vol., 81, No., 3, 1994, pp. 190-94.

This is not to suggest that such professional control has been guided by strictly self-serving motives. I suspect that most of the physicians who have served on medical boards have done so at considerable sacrifice and with the best of motives. That certainly is the case for many of the physicians I know who have served on these boards. The professional control, in effect, has been a reflection of an implicit contract that has governed the physician-patient relationship for many decades. Patients, aware of their great dependence on medical knowledge and skills, have granted physicians extensive latitude in the practice of their profession. Physicians, in exchange, have agreed to adhere to a service ethic that gives primacy to the well-being of their patients.

The Emerging Public Protection Model of Professional Regulation

But the underpinnings of the self-regulation model are now giving way. In part that is happening because of market forces that give organizations and managers more influence over the practice of medicine. In even greater part, it is happening, and increasingly will happen, because of rapid advances in medical and information technology. In many ways such technology is beginning to help consumers gain access to medical products they can use themselves and to information on their own medical condition, on treatment options, and even on the performance of their physicians. At the same time, physicians are increasingly capable of immediately accessing a wide variety of clinically-relevant information that they can use to help consumers participate more fully in their medical care.

In a recent, compelling survey of these trends, The Economist concluded that before long the implicit contract between doctors and patients will have to be rewritten. Patients, not doctors, The Economist confidently asserts, will come to drive the health care system.[2]

As these developments unfold, medical boards face increasing pressure to be responsive to the needs and concerns of consumers. Across the country, this pressure tends to get expressed in various ways. It leads to efforts to increase the proportion of nonphysician members of medical boards, as has happened most dramatically in neighboring Rhode Island where 50 percent of the board members are not physicians. It leads to calls for medical boards to become more proactive in identifying the few poorly performing physicians who pose a danger to their patients (the "bad apples") and to deal firmly with those physicians once they are identified. And, as we have seen here in Massachusetts, it leads to demands for public disclosure of information that can help the public assess the performance of physicians.

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[2] "The Future of Medicine," The Economist, March 19, 1994, pp. 1-18.

THE PRINCIPLES

As you decide how much and what kind of information to make available to the public, I strongly suggest that you move in a direction that is consistent with and even anticipates the emerging patient-driven health care system and the pressures for greater public accountability now being exerted on state medical boards. Toward that end, I suggest the following as working principles:

1. **Be as open as possible in giving consumers access to information that can be helpful to them in making choices about their health care.** Don't reach for a standard of disclosure that is so high that little information will, in fact, be disclosed. It will not be credible to the public. Just what kind of information about physicians should be disclosed? Unquestionably, consumers should have access to all adverse actions taken against physicians by regulatory boards, health care institutions, and professional associations. They should probably also have access to information on settled medical malpractice claims, even though the information is generally likely to be less indicative of a physician's competence. And, as reliable outcome data on the performance of physicians become available, they should be entitled to that information. A good test here is to ask: what would I want to know about a physician treating me or a member of my family?

2. **Facilitate public access to the information.** It is one thing to make information accessible and then to leave it to the resourcefulness of consumers to figure out how to get it. It is quite another to make it available in ways that make it relatively easy for consumers to know the information exists and how to obtain it. Thus, an active effort at dissemination would seem to be important if public disclosure is to be regarded as a serious measure intended to help the public make better decisions. That effort could involve many different kinds of dissemination, ranging from public releases to news media, to the regular distribution of written information, to the establishment of an 800 number, to appearances before consumer groups, and, lest we forget, to the use of computer bulletin boards and other features of the information superhighway.

3. **Help consumers interpret the information.** Physicians are often concerned that consumers will be confused and/or misled by information made available to them. Instead of addressing those concerns by making little information available, it would be preferable to make more information available but in ways that help the public put it in proper context. If, for instance, there is a concern that consumers will make too much of settled malpractice claims involving a physician, then present it in ways that help them understand the number of such claims typically settled against physicians in the same specialty area. But let us beware here. Too ambitious an effort to interpret can add unnecessary delay and complexity. It can also be disrespectful of the consumers' capacity to exercise good judgment.

THE PERFORMANCE OF THE MEDICAL BOARD

I recognize that your inquiry focuses on what information concerning physician care should be disclosed to the public. However, I suggest that you also consider how the public might become more informed about the performance of the Board of Registration in Medicine itself. After all, the Board is supposed to provide a vital front line of protection for the public. While others in the quality assurance field focus on ways to improve the norm in medical care, the Board has a less exhilarating, but no less important role to ensure that minimum standards are met and to help protect the public from harm.

I bring this issue up, in closing, because there is a very practical instrument available to collect information about the performance of state medical boards. It is "The Self-Assessment Instrument" developed primarily by physicians with experience on state medical boards. Through the use of this instrument, which is available through the Federation of State Medical Boards, the Board can identify its own strengths and weaknesses and can compare how it ranks on any number of performance indicators with other similar boards. It is certainly not a perfect tool, but it is a good beginning. If the Board used it to assess its performance and made the information available to the public (with appropriate explanations), it would be making a strong statement about its accountability to the public. Such disclosure about the Board's own performance would be an effective complement to the broad disclosure of information on physician care.

APPENDIX 5:

Select portions of the Board of Registration in Medicine Application for Medical Licensure and Renewal Application

THE COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE

FEE: $350.00 TO BE SUBMITTED

Filed: _____ For Office Use Application # _____

By: _____

Form of Fee: _____ Certificate # _____ Date of Issue _____

Please Print

SWORN STATEMENT

Date: _____

Name _____ Address _____
First *Middle* *Last*

Date of Birth _____

Place of Birth _____

Name on Birth Certificate _____ Phone # _____

Pre-Medical Education

School _____

Years Attended _____

Medical Education

School _____

Years Attended _____

Postgraduate Education & Hospital Appointments from graduation from Medical School to the present time.

Place	Position	Dates

Is this your first full license? ___ If applicable, please list all other states where you are or have been licensed:

_____

Other names under which you have been licensed:

_____

List Specialty Boards by which you are certified: _____

_____

REASON APPLYING FOR A MA LICENSE _____

Anticipated starting date if you have position pending in Massachusetts: ___/___/___

NOTE: Change of address must be submitted to the Board of Registration in Medicine in writing. Please include effective dates of new address.

AFFIDAVIT OF APPLICANT:
I, the undersigned applicant, hereby certify that all information included in this application for licensure constitutes a true statement made under penalty of perjury.

_____ Date: ___/___/___
SIGNATURE OF APPLICANT

CERTIFICATE OF MORAL AND PROFESSIONAL CHARACTER

ATTENTION APPLICANT: This certificate must be signed by a physician legallly authorized to practice medicine in the United States. This statement should be executed by someone other than a relative who knows you well and for a substantial period of time. The Board especially seeks statements from physicians licensed to practice in Massachusetts. PLEASE HAVE CERTIFYING PHYSICIAN RETURN DIRECTLY TO THE BOARD.

PHOTOGRAPH	**CERTIFICATE OF MORAL & PROFESSIONAL CHARACTER**
Attach hereto a recent 2 x 2 photograph. You must sign your name in the presence of a NOTARY PUBLIC to whom you are personally known.	This certifies that I have been personally acquainted with (NAME) (ADDRESS) for____years; that I believe h____ to be of good moral & professional character, and in every respect worthy of confidence. I recommend h___ to the Massachusetts Board of Registration in Medicine.
Signature of Applicant	_____M.D. Signature of certifying physician
I certify that the photograph above is a genuine likeness of the maker of the signature above.	NAME TYPED OR PRINTED ADDRESS of certifying physician
Signature of Notary	License #_____State_____
(Expiration Date of Commission)	DATE:___/___/___

CERTIFYING PHYSICIAN: PLEASE RETURN DIRECTLY TO: THE BOARD OF REGISTRATION IN MEDICINE, 10 WEST ST., BOSTON, MA 02111

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

FORM E

VERIFICATION OF PREMEDICAL AND MEDICAL INSTRUCTION AND GRADUATION

INSTRUCTIONS TO THE DEAN OR DESIGNATED OFFICIAL OF MEDICAL SCHOOL

Please complete this form in full and return it DIRECTLY TO THE ADDRESS ABOVE. This Verification cannot be accepted nor can a license be issued to the applicant unless you send this form directly to the Board of Registration in Medicine. Thank you for your cooperation.

I CERTIFY THAT _____ CREDITABLY
NAME OF APPLICANT

COMPLETED AT LEAST TWO YEARS OF A PREMEDICAL COURSE INCLUDING PHYSICS, BIOLOGY, INORGANIC AND ORGANIC CHEMISTRY AT:

_____
NAME AND LOCATION OF UNDERGRADUATE EDUCATIONAL INSTITUTION

_____
NAME AND LOCATION OF SECOND UNDERGRADUATE INSTITUTION (IF APPLICABLE)

for admission to: _____
NAME OF MEDICAL SCHOOL

_____
LOCATION OF MEDICAL SCHOOL (CITY, STATE, COUNTRY)

I FURTHER CERTIFY THAT _____
NAME OF APPLICANT

HAS COMPLETED AND ATTENDED FOR _____ ACADEMIC YEARS OF INSTRUCTION,
NUMBER

OF NOT LESS THAN THIRTY TWO WEEKS IN EACH ACADEMIC YEAR

AT: _____
NAME OF MEDICAL SCHOOL

CONTINUED ON BACK OF THIS PAGE

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

An Agency within the Executive Office of Consumer Affairs and Business Regulation

FORM E CONTINUED

NAME OF APPLICANT_____

TO MEDICAL SCHOOL: Give exact dates of instruction, including month, day of month and year for each year to show the number of weeks, excluding vacations, in each year.

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

FROM:_____ TO:_____
MONTH DAY YEAR MONTH DAY YEAR

AND HAS RECEIVED/WILL RECEIVE A DEGREEE OF_____

ON_____19_____.

_____
SIGNATURE OF DEAN OR DESIGNATED OFFICIAL

_____
NAME AND TITLE (PLEASE TYPE OR PRINT)

SCHOOL SEAL

DATE:_____

FORM B

VERIFICATION OF FLEX EXAMINATION

STATE MEDICAL BOARD OF_____

NAME_____

being duly sworn, says that she/he is Secretary

of_____

and that DR._____of_____

took the FLEX examination on _____
(DATE OF EXAMINATION)

and obtained the following scores:

FLEX prior to June, 1985 - FLEX WEIGHTED AVERAGE OF_____
ALL THREE DAYS TAKEN IN ONE SITTING
PASSING GRADE WAS_____.

CURRENT FLEX - COMPONENT ONE_____COMPONENT TWO_____
PASSING GRADE IS_____.

_____
SECRETARY

Sworn to before me this_____DAY OF_____

_____
SIGNATURE OF NOTARY PUBLIC EXPIRATION DATE OF COMMISSION

LICENSE WAS NOT ISSUED FOR THE FOLLOWING REASON(S)_____

_____

DEROGATORY INFORMATION_____

_____

Seal of the Board must be affixed.

RETURN FORM DIRECTLY TO: THE BOARD OF REGISTRATION IN MEDICINE
TEN WEST ST., THIRD FLOOR, BOSTON, MA 02111

RETURN TO: BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, THIRD FLOOR, BOSTON, MA 02111

VERIFICATION OF LICENSURE

In applying for a license to practice medicine in the Commonwealth of Massachusetts, the Board of Registration in Medicine requires that this form be completed by each state where I hold or have ever held licensure. This is your authority to release any information in your files, favorable or otherwise. Please send this form directly to the Board at the above address. Your early response is greatly appreciated.

SIGNATURE OF PHYSICIAN:_____

NAME OF PHYSICIAN:_____LICENSE NUMBER:_____

THE STATE BOARD FILLS OUT THE FOLLOWING INFORMATION

State of:_____Full Name of Licensee:_____

Graduate of:_____

License Number:_____Issue Date:_____

Endorsement/Reciprocity with:_____

By Your State Board's Written Examination?_____Yes_____No

Is License Current: Yes No

If no, why not?_____

Has this License been suspended or revoked?_____YES_____NO
If yes, why?_____

Has Licensee ever been on probation?_____YES_____NO
If yes, why?_____

Has Licensee ever been requested to appear before your Board?__YES__NO
If yes, why_____

DEROGATORY INFORMATION, IF ANY?_____

Comments:_____

Signed:_____Date:_____

Title:_____

STATE SEAL STATE BOARD_____

NOTE TO APPLICANT: Most states charge a fee for this service. We suggest you call the different states in which you are licensed before you mail this form.

Certification of Post-Graduate Training FORM G

Instructions: This form must be completed and signed by the Director of your internship or residency training program. If you had postgraduate training in more than one program, this form may be duplicated. Upon proper completion, this form must be returned directly by the hospital to the Board's address below.

I, _____ (Name), _____ (Title)

hereby certify that _____ has served _____ year(s)

of post-graduate training as a _____ (Position) in _____ (Specialty)

at _____ (Hospital), _____ (City). _____ (State).

This program is _____ is not _____ approved by the ACGME or the RRC.

Dr. _____ participated in this program from

_____ (Month), _____ (Year) to _____ (Month), _____ (Year) and was issued _____ was not issued _____ a certificate as proof of completion of said training. (If not issued a certificate, please explain.)

_____

_____

I further certify that at the time of completion of the above training, this physician was, to the best of my knowledge, competent to practice medicine and there was no disciplinary action outstanding or pending involving him or her.

_____
Signature of Director

_____
Date

Hospital Seal

RETURN THIS FORM DIRECTLY TO: COMMONWEALTH OF MASSACHUSETTS
BOARD OF REGISTRATION IN MEDICINE
TEN WEST STREET, 3RD FLOOR,
BOSTON, MASSACHUSETTS 02111

ALEXANDER F. FLEMING
EXECUTIVE DIRECTOR

Commonwealth of Massachusetts
Board of Registration in Medicine

Ten West Street
Boston, Massachusetts 02111

(617) 727-3086

An Agency within the Executive Office of Consumer Affairs and Business Regulation

EVALUATOR, PLEASE RETURN DIRECTLY TO THE BOARD

Please complete all parts of this form. If more room is needed, please attach a separate sheet of paper.

I. VERIFICATION

Dr. _____ was at _____

from _____ to _____. During that time (s)he was

_____
List status in the institution

II. EVALUATION

(H)she has listed your name as one who has requisite knowledge through recent observation of his/her current clinical competence, ethical character, and ability to work cooperatively with others. In this regard, please complete the following evaluation.

IMPORTANT NOTE: If you rate the candidate "poor" or "fair" in a particular category, please elaborate on this aspect of the evaluation in as much detail as possible.

	POOR	FAIR	GOOD	SUPERIOR
Basic medical knowledge				
Professional judgment				
Sense of responsibility				
Ethical conduct				
Competence and skill				
Cooperativeness, Ability to work with others				
Appearance				
History & Physical Exam taking				
Record keeping				

CONTINUED ON BACK OF THIS PAGE

	POOR	FAIR	GOOD	SUPERIOR
Case Presentations				
Physician-Patient Relationship				
Ability to understand and speak English				
Participating in Medical Staff Affairs				

III. In addition to the above, will you please write a letter, or use the space below and the reverse side for elaboration on the above and any additional information you have available to aid us in evaluating this applicant. Thank you for your cooperation.

IV. Of particular value to us in evaluating any candidate are comments regarding his/her notable strengths and/or weaknesses. We would appreciate such comments from you. Any additional information should be attached to this form.

_____

_____

_____

_____

V. The above report is based on

1. Close personal observation _____
2. General impression _____
3. A composite of previous evaluations by other physicians _____
4. Other _____

I further certify that at the time of completion of the above training, or during my association with the physician, he/she was competent to practice medicine and he/she was not the subject of any disciplinary action.

I recommend _____ for licensure in Massachusetts.
Name of physician

Signed: _____

Date: __/__/__ _____
(Please type or print full name and title)

COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE SUPPLEMENT TO APPLICATION FOR _____ LICENS

TO BE COMPLETED BY APPLICANT. PLEASE TYPE OR PRINT.

NAME: _____ Day time phone #: _____

MAILING ADDRESS: _____ Business Address:

_____

Address valid until: _____

YOU ARE REQUIRED TO COMPLETE THE QUESTIONS BELOW.

IMPORTANT NOTE: The Board's regulations, 243 CMR 3.02, define "disciplinary action" as referred to in the questions on this application. Please consult this definition, which follows this portion of the application.

	YES	NO
1. Has any medical malpractice claim been made against you in the last ten years (whether or not a lawsuit was filed in relation to the claim)? (You must complete Form 1B, attached, for each claim)	___	___
2. Have you ever been denied the right to participate or enroll in any system whereby a third party pays all or part of a patient's bill?	___	___
3. Have you ever applied for licensure or to sit for an examination or taken an examination under a different name? If so, previous name: _____	___	___
4. Have you ever been denied the privilege of taking or finishing an examination or been accused of cheating and/or improper conduct during an examination or otherwise been subject to any disciplinary action (see definition) at an academic institution since your matriculation in college?	___	___
5. Have you ever failed any of the following examinations: the FLEX examination, any state Board examination, failed Part III of the National Boards or failed to gain certification from the National Board of Medical Examiners?	___	___
6. Have you ever failed a foreign licensing or certification examination?	___	___
7. Have you ever been denied a medical license, whether full, limited or temporary, for any reason?	___	___
8. Have you ever had staff privileges, employment or appointment in a hospital or other health care institution denied, suspended or revoked, or resigned from a medical staff in lieu of disciplinary action (see definition)?	___	___
9. Are any formal disciplinary charges pending or has any disciplinary action (see definition) been taken against you in the last ten years by any governmental authority, by any hospital or health care facility, or by any professional medical association (international, national, state or local)?	___	___
10. Have you ever voluntarily surrendered a license to practice medicine or any healing art?	___	___
11. Have you ever withdrawn an application for medical licensure, hospital privileges or appointment, for any reason?	___	___
12. Have you ever, for any reason, lost American Specialty Board Certification?	___	___
13. Have you been denied required recertification by one or more specialty boards? If yes, which one(s)? _____ _____	___	___
14. Have you, at any time, been a defendant in any criminal proceeding other than minor traffic offenses?	___	___
15. Has your privilege to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted or surrendered, or have you been called before or warned by this state or any other jurisdiction including a federal agency at any time?	___	___
16. Have you ever had any emotional disturbance or mental illness which has impaired your ability to practice medicine or to function as a student of medicine?	___	___
17. Have you ever had an organic illness which has impaired your ability to practice medicine or to function as a student of medicine?	___	___
18. Are you now, or have you been in the past, dependent upon alcohol or drugs?	___	___
19. Has any professional liability insurance provider restricted, limited, terminated, or imposed a surcharge on your coverage?	___	___
20. Have you ever been enrolled in a residency training program(s) that you did not complete?	___	___

IMPORTANT: SEE FOLLOWING PAGES FOR FURTHER INFORMATION REQUIRED FOR "YES" ANSWERS.

NOTE ON QUESTIONS 16-18: The harm that befalls physicians and patients alike when impairment goes undetected and untreated by the medical profession is devastating. The Board wants impaired physicians treated in the early stages of impairment before irreparable harm to the physician or patient occurs.

IF RESPONSES TO QUESTIONS CHANGE DURING THE TIME THE APPLICATION IS PENDING, THE APPLICANT MUST MAKE THE BOARD AWARE OF THE NEW INFORMATION.

I certify that I will fulfill my obligation to report abuse or neglect of children pursuant to M.G.L.c.119 sec. 51A.
I will read the Board's regulations, 243 CMR 1.00 through 3.00. To the best of my knowledge I meet the qualifications for full licensure in Massachusetts.

I hereby certify under the penalty of perjury that all information on this application, (front, back, and all attachments) is true.

SIGNATURE: _____ DATE: _____

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111

FORM : 8

Question 1

PLEASE SUPPLY THE FOLLOWING INFORMATION REGARDING EACH INSTANCE OF ALLEGED MALPRACTICE: THIS FORM SHOULD BE PHOTOCOPIED AND FILLED OUT SEPARATELY FOR EACH CLAIM; Additional sheets may be attached if necessary. Please type or print clearly.

Applicant name:_____

Insurer:_____ Claimant Name:_____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability. See Table 5 attached.)

Basis Code:_____ Basis Code:_____ Basis Code:_____ Basis Code:_____ Basis Code:_____

Basis Code:_____ Basis Code:_____ Basis Code:_____ Basis Code:_____ Basis Code:_____

ADDITIONAL DESCRIPTIVE INFORMATION: Please indicate: 1) patient's condition at point of your involvement; 2) patient's condition at end of treatment; 3) the nature and extent of your involvement with the patient; and
4) your degree of responsibility for the course of treatment in leading to the claim.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

If incident resulted in patient's death, indicate cause of death according to autopsy or patient chart:_____

PLEASE NOTE: Submission of copies of pertinent medical records will be necessary in some instances.

Incident Location (circle one):

01 Emergency Room	02 Labor/Delivery	03 Laboratory/X-Ray/Testing	04 Operating Room
05 Outpatient	06 Patient Room	07 Hospital-Other	08 Hospital-Unknown
09 HMO	10 Clinic	11 Nursing Home	12 Physician's Office
13 Walk-In Center	14 Other	15 Unknown	

Your Role (circle one):

01 Anesthesiologist	02 Primary Care Physician	03 Referring Physician
04 Attending Physician	05 Consultant Specialist	06 Surgeon
07 Fellow	08 PGY 7	09 PGY 6
10 PGY 5	11 PGY 4	12 PGY 3
13 PGY 2	14 PGY 1	15 Physician's Assistant
16 Nurse Anesthetist	17 Nurse	18 Nurse's Aide
19 Midwife	20 Psychotherapist/Allied Mental Health & Human Services Professional	21 Dentist
22 Acupuncturist	23 Administration	24 Group Practitioner/Partner
25 Medical Technician	26 On-Call Physician	27 Workmen's Comp Evaluator
28 Court Psychiatrist	98 Other	99 Unknown

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111

Applicant name:_____
Last name First name Middle initial

Question 1 (cont.)

Legal Representative:(include name, address and telephone #)

_____

_____

_____

If a medical malpractice tribunal has heard your case, indicate the following: Finding for: YOU___ PLAINTIFF___ Date:___/___/___
If the Court has heard your case, indicate the following: Decision determined by (Check one): JUDGE___ JURY___
Decision:_____ Award:_____
If your case was appealed, indicate the following: Date Appeal Filed:___/___/___ Date Appeal Decided:___/___/___
If your case was settled, indicate the following:
Settlement amount paid on your behalf:_____
Total settlement amount:_____
Date of settlement: ___/___/___
Case dismissed against you ____ against all defendants _____

IMPORTANT: IN ADDITION TO THE ABOVE INFORMATION, PLEASE ATTACH A CERTIFIED COPY OF THE COMPLAINT AND FINAL JUDGMENT, SETTLEMENT & RELEASE, OR OTHER FINAL DISPOSITION OF THE CLAIM.

Additional information if any:

_____

_____

_____

_____

_____

_____

_____

_____

Questions regarding documentation required by affirmative responses to malpractice claim question should be directed to the Board's Licensing Attorney.

Applicant name; Last name, first name, middle initial:_____

ADDITIONAL INFORMATION RELATED TO QUESTIONS 2 THROUGH 20 EXCEPT #3 AND 19. If you answered YES to any of Questions 2 - 20 (except # 3, 19) please provide the following information where applicable.

QUESTIONS 2, 4, 8: Attach additional sheets (with same format) where necessary.

Organization:_____
Action:_____

QUESTION 5 & 6: Exam failure:_____Date: _____ Date passed: _____ (attach additional sheets with same format where necessary)

QUESTION 7, 10, 11: Withdrawal, Surrender or Denial of License, or privileges, or appointment: Attach additional sheets (with same format) where necessary. State:_____ Year:_____ Circumstances under which license privileges or appointment was withdrawn or denied (revoke renewed, or otherwise terminated):_____
_____
_____
_____

Please attach a copy of all official correspondence relative to the withdrawal, denial or voluntary surrender of your license privileges or appointment which should specify the reasons for the withdrawal, denial or voluntary surrender.

QUESTION 12: Attach explanation of circumstances pertaining to loss of specialty board certification, including date, name of Board involved.

QUESTION 9: Disciplinary Action (see definition below): Attach additional sheets (with same format) where more than one action taken or pending and where otherwise necessary.

DEFINITION OF DISCIPLINARY ACTION

A "disciplinary action" is an action adversely affecting a licensee which simultaneously meets the descriptions in subsections (1), (2) and (3) below, and which is imited as described in subsections (4) and (5) below:

(1) an action of an entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, or local).

(2) An action which is:

(a) formal or informal, or

(b) oral or written. (However, an oral reprimand is not a "disciplinary action."

(3) Any of the following actions or their substantial equivalents, whether voluntary or involuntary:

(a) Revocation of a right or privilege.

(b) Suspension of a right or privilege.

(c) Censure.

(d) Written reprimand or admonition.

(e) Restriction of a right or privilege."

(f) Non-renewal of a right or privilege."

(g) Fine.

(h) Required performance of public service.

(i) A course of education, training, counseling, or monitoring, only if such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee's competence to practice medicine.

(j) Denial of a right or privilege."

(k) Resignation.

(l) Leave of absence.

(m) Withdrawal of an application.

(n) Termination or non-renewal of a contract with a licensee."

"(4) Divisions (e), (f), and (j) through (n) above are "disciplinary actions" only if they relate, directly or indirectly to:

(a) the licensee's competence to practice medicine, or

(b) a complaint or allegation regarding any violation of law or regulation (including, but not limited to, the regulations of the Massachusetts Board of Registration in Medicine or other state licensing Board) or bylaws of a health care facility, medical staff, group practice, or professional medical association, whether or not the complaint or allegation specifically cites violation of a specific law or regulation.

(5) If based upon a failure to complete medical records in a timely fashion or failure to perform minor administrative functions, the action adversely affecting the licensee is NOT a "disciplinary action" for the purposes of mandatory reporting to the Board, provided that the adverse action does not relate directly or indirectly to:

(a) the licensee's competence to practice medicine, or

(b) a complaint or allegation regarding any violation of law or regulation, whether or not the complaint or allegation specifically cites violation of a specific law or regulation.

See Board Regulations 243 CMR 3.02.

Name of Organization taking action:_____

Date: __/___/___

Duration:_____

Description:_____

Please submit copies of all documents relating to the action in question. This should include correspondence between the institution or agency and yourself regarding action or contemplated action by the institution, minutes of institutional or agency committees which considered your privileges, reports by peer review committees, consultants or case reviews within or without the institution or agency.

QUESTION 14: Criminal Proceedings Attach additional sheets (with same format) where more than one charge and where otherwise necessary.

Court:_____ Charge:_____ Date:___/___/___

Please attach a detailed account of the circumstances leading to criminal proceedings.

Status:_____

Please arrange for the submission of certified copies of the indictment, complaint and judgment or other disposition in any criminal proceedings in which you were a defendant.

QUESTION 15: Privileges to Prescribe Controlled Substances: Attach additional sheets (with same format) where necessary.

Type of Restriction:_____ Date:___/___/___

Circumstances of restriction: _____

_____

_____

_____

Please attach copies of all official orders, findings of fact, and correspondence related to this warning or sanction.

QUESTIONS 16 through 18: Treatment for Mental Illness, Organic Illness, Alcohol or Drug Dependency: Attach additional sheets (with same format) where necessary.

Treating Organization:_____ Telephone:(___)___-____

Address:_____

Person Responsible for Treatment:_____

Type of Condition and Treatment:_____

_____

_____

_____

_____

Dates of Illness/Dependency:___/___/___ to :___/___/___ Dates of Treatment:___/___/___ to :___/___/___

Please note additional documents requested below:

QUESTION 16: Please submit copies of all discharge summaries, clinical notes or other documentation regarding treatment of your mental illness, and an evaluation of your current mental and emotional status by a psychiatrist performed not later than six months prior to the date of application.

QUESTION 17: Please submit a medical evaluation from your physician, performed within six months of the date of your application, indicating the current state of your physical impairment.

QUESTION 18: Please submit copies of all discharge summaries, clinical notes, or other documentation regarding the treatment of your drug/alcohol dependency, and an evaluation of your current status with respect to the dependency, performed by or supervised by a physician, not later than thirty days prior to the date of your application.

QUESTION 19: Liability Insurance Actions: You must answer "yes" if an action has been taken against your professional liability insurance coverage. An "action the following or their substantial equivalents: restriction, limitation, termination or imposition of a surcharge.

QUESTION 20: If yes, please attach an explanation detailing your reason for not completing the program(s). In addition, you must provide a letter from the Program Director of the training program which you did not complete, certifying the circumstances under which you left the program.
This letter must be sent directly to the Board by the Program Director.

* * * * *

Please Note: Additional information about the above items may be requested by the Board. Questions regarding required documentation for affirmative responses to these questions should be addressed to the Board's Licensing Attorney.

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Application

Registration No.	Status	Fee	Renewal Date	Late Fee
		$250.00		$25.00

Mailing Address:

Correction of Mailing Address

Address (Mailing): _____

_____

City/Town: _____

State: _____

Country: _____

Directions: Before proceeding, please read the instruction booklet. Some questions are optional.

- **Failure to renew in a timely manner will cause your license to lapse and may affect your ability to practice medicine in the Commonwealth. (See enclosed letter).**
- **Add late fee if necessary.**
- **Make a copy of this form and all attachments for your own records** - you will need copies for credentialing and other purposes. The Board will charge a fee for each copy it provides.
- See instructions on detachable coupon at bottom of this page.

For Office Use Only

M.R. _____

Pr. _____

Bk/D.B. _____

Pre-Printed Information

1. Other name(s), if any, under which you were licensed:

2.

3. Date of Birth: Sex:
   Lic. Issue Date: SS#:

   Home Phone Business Phone

4. Name of Medical School:

   Year Graduated: Degree:

5. a) Other states where you are now licensed to practice (Abbr):
   b) States where you previously were licensed to practice (Abbr):

6. Specialty Code(s) (See Table 1):
   Code Hours per Week in Mass.

7. If you are currently American Specialty Board certified, enter codes: (See Table 2)
   Code: Code:

8. Drug license number(s), if any:
   a) Federal (DEA)
   b) Massachusetts

Corrections of Pre-Printed Information

Name: _____

Address: _____

City/Town: _____

State: _____ Zip: _____

Country: _____

Date of Birth (M/D/Y): __/__/__ Sex (M/F): _____

Lic. Issue Date (M/D/Y): __/__/__ SS#: _____

Home: ( ) _____ Business: ( ) _____

Full Name of Medical School: _____

_____

Year Graduated: _____ Degree (MD/DO): _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Code Hours per Week in Mass.

_____ _____

_____ _____

If OS, print specialty: _____

Code: _____ Code: _____

Federal (DEA): _____

Mass: _____

9. Activity Status: I am applying to be registered with the following status: ACTIVE ____ INACTIVE ____

- **I hereby certify that if requesting Inactive status, I will not practice medicine, including writing prescriptions, in Massachusetts.**

PRINT NAME AND NUMBER: Physician Last Name: _____ Registration Number: _____

10. a) Current health care facility(ies) at which you have completed the credentialing process for the provision of patient care. Supply the codes from Table 3 and place a check mark next to those facilities where you have admitting privileges (AP).

Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP) Facility Code: ___ ___ ___ / ___ (AP)

If 999, print name(s): _____

b) Additional hospitals at which you previously held privileges and other health care facilities with which you were associated in the past 2 years. (See Table 3)

Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___ Facility Code: ___ ___ ___

If 999, write name(s): _____

11. My medical malpractice insurance is covered by (a) Insurance Carrier ___ (b) Letter of Credit ___ If applicable, check one.

List Insurer: _____

Alternatively, indicate as follows: I am registering with ACTIVE status, but I am not covered by medical malpractice insurance because I am (Check One): (i) Not involved in direct/indirect patient care in Massachusetts: _____ (ii) Otherwise exempt: _____

State how otherwise exempt: _____

12. Are you currently in a post-graduate training program in Mass. as a resident or clinical fellow? Yes ___ No ___ (Check one)

13. a) What is your principal work setting? (See Table 4) ___ ___

b) Care of patients in Massachusetts (See instruction booklet.)

i) How many hours per typical week are you currently involved in *outpatient* care in Mass? ___ hrs/wk

ii) How many hours per typical week are you currently involved in *inpatient* care in Mass? ___ hrs/wk

c) Approximately what percentage of your patient care hours are in primary care? (See instructions for definition of primary care.) _____ %

Questions **14 through 24** refer **to the past two years only.** Check either YES or NO (NOT N/A) to each question. Provide details on Forms R-1 and R-2 for all YES answers. **Refer to the instruction booklet for additional information and definitions.**

IN THE PAST TWO YEARS:	**YES**	**NO**
14. **CLAIMS MADE:** Has any medical malpractice claim been made against you which has not yet been finally settled or adjudicated, whether or not a lawsuit was filed in relation to the claim?	___	___
15. **CLAIMS RESOLVED:** Has any medical malpractice claim against you been settled, adjudicated or otherwise resolved, whether or not a lawsuit was filed in relation to the claim?	___	___
16. Has any lawsuit, other than a medical malpractice suit, which is related to your competency to practice medicine, or your professional conduct in the practice of medicine, been filed against you by a patient, or been settled, adjudicated or otherwise resolved?	___	___
17. Have you been charged with any criminal offense, other than a minor traffic violation?	___	___
18. Have you been formally charged with or disciplined for any violation of the rules, by-laws or standards of practice of any governmental authority, health care facility, group practice or professional society or association?	___	___
19. Has your privilege to possess, dispense or prescribe controlled substances been surrendered to or suspended, revoked, denied or restricted by any state or federal agency?	___	___
20. Have you withdrawn an application for a medical license or been denied a medical license for any reason?	___	___
21. Has any professional liability insurance provider restricted, limited, terminated or imposed a surcharge on your coverage or have you voluntarily restricted, limited or terminated your insurance coverage in response to an inquiry by a professional liability insurance provider?	___	___
22. Have you been diagnosed with or do you have a medical condition which limits or impairs your ability to practice medicine?	___	___
23. Have you engaged in the use of any chemical substance(s) which in any way interfered with your ability to practice?	___	___
24. Have you voluntarily modified or otherwise limited your scope of practice of medicine for any reason other than a medical condition?	___	___

25. I have completed my CME requirements in the two years preceding my renewal date: Yes _____ No, waiver requested _____

No, training program exemption (see instruction booklet). _____

If requesting a waiver you must fill out a separate Waiver Form. The waiver must be granted by the Board before your license will be renewed. See instructions for CME requirements. Do not submit documentation of your CMEs with your renewal application.

- **Pursuant to G.L. c. 112, sec. 2, I will not charge to or collect from a Medicare beneficiary more than the Medicare reasonable charges.**
- **Pursuant to G.L. c. 62 C, sec. 49A, I hereby certify under the pains and penalties of perjury that, to the best of my knowledge and belief, I have filed all Massachusetts state tax returns and paid all Massachusetts state taxes that are required under law. NOTE: This applies even if you reside out-of-state or out of the United States.**
- **Pursuant to G.L. c. 112, sec. 1A, I hereby certify that I will fulfill my obligation to report abuse or neglect of children as required by G.L. c. 119, sec. 51A.**
- **I hereby certify under the pains and penalties of perjury that all information on this form and Forms R-1 and R-2 is true.**

Signature: _____ Date: ___/___/___

Version 1.1

FORM R-1

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Form R-1

Additional Information Related to **QUESTIONS 14, 15 and 16**. If you answered "YES" to any of these questions, provide the following information where applicable. Attach additional sheets (with same format) where necessary. It is not adequate to state that the Board already has the information.

Physician Name:_____ Registration No:_____

Insurer (at the time of incident):_____ Policy No.:_____

Patient Name:_____

Incident Date: ____/____/____ to ____/____/____

Description of Alleged Basis(es) of Claim (Allegations Only: This does not constitute an admission of fault or liability. See *Table 5.)*

Basis Code: __ __ __ Basis Code: __ __ __ Basis Code: __ __ __ Basis Code: __ __ __ Basis Code: __ __ __

Narrative:_____

_____

_____

_____

Incident Location (circle one):

01 Emergency Room	02 Labor/Delivery	03 Laboratory/X-Ray/Testing	04 Operating Room	05 Outpatient
06 Patient Room	07 Hospital - other	08 Hospital - Unknown	09 HMO	10 Clinic
11 Nursing Home	12 Physician's Office	13 Walk-In Center	14 Other:_____	

Your Role (circle one):

01 Anesthesiologist	02 Primary Care Physician	03 Referring Physician	04 Attending Physician	05 Consultant Specialist
06 Surgeon	07 Fellow	08 PGY 7	09 PGY 6	10 PGY 5
11 PGY 4	12 PGY 3	13 PGY 2	14 PGY 1	23 Admin/Supervisor
24 Group Practitioner/Partner	26 On-Call Physician	27 Worker's Comp Evaluator	28 Court Psychiatrist	98 Other:_____

If court action was filed, fill out the following:

Venue (circle one):

01 Barnstable	02 Berkshire	03 Bristol	04 Dukes	05 Essex	06 Franklin	07 Hampden	08 Hampshire
09 Middlesex	10 Nantucket	11 Norfolk	12 Plymouth	13 Suffolk	14 Worcester	50 Federal	99 Out of State

Docket Number:_____ Case Name (Parties):_____

If Medical Malpractice Tribunal has heard your case, indicate the following:

Finding for: YOU _____ PLAINTIFF _____ Date ____/____/____

If the Court has heard your case, indicate the following: Decision determined by (Check one): JUDGE_____ JURY_____

Decision: _____ Award: _____

If your case was appealed, indicate the following: Date Appeal Filed: ____/____/____ Date Appeal Decided: ____/____/____

Decision:_____

If your case was settled, indicate the following: Total Settlement Amount: _____ Date: ____/____/____

Amount allocated to you: _____

Final result, if different from above: _____ Date: ____/____/____

Signature:_____ **Date:** ____/____/____

FORM R-2

Commonwealth of Massachusetts Board of Registration in Medicine
Ten West Street, 3rd Floor, Boston, Massachusetts 02111
1995-1997 Physician Registration Renewal Form R-2

Additional states where you are now licensed to practice (Abbr):

_____ _____ _____ _____ _____ _____

Additional states where you previously were licensed to practice (Abbr):

_____ _____ _____ _____ _____ _____

Additional Information Related to **QUESTIONS 17 through 24**. If you answered "YES" to any of these questions, provide the following information where applicable. Attach additional sheets (with same format) where necessary. It is not adequate to state that the Board already has the information.

Physician Name:_____ Registration No: _____

17. Criminal Proceeding

Court: _____ Charge: _____ Date: ___/___/___

Description: _____

_____

_____

Status: _____

18. Disciplinary Action

Name of Organization taking action:_____ Date: ___/___/___

Duration: _____

Action Taken or Action Pending (circle all that apply):

01 Revocation of right or privilege	02 Suspension of right or privilege	03 Censure
04 Written reprimand or admonition	05 Restriction of right or privilege	06 Non-renewal of right or privilege
07 Fine	08 Required performance of public service	09 Education/Training/Counseling/Monitoring
10 Denial of right or privilege	11 Resignation	12 Leave of absence
13 Withdrawal of an application	14 Termination or non-renewal of contract	
16 Probation	17 Assurance of Discontinuance	18 Consent Agreement
19 Letter of Agreement	20 Expulsion from Membership	98 Other

Reasons for action *(See Table 5)*: Basis Code: __ __ __ Basis Code: __ __ __ Basis Code: __ __ __

Description:_____

_____

_____

_____

_____

Signature:_____ **Date:** ____/____/____

(see reverse side for **QUESTIONS 21 TO 24**)

19. Privilege to Prescribe Controlled Substances

Type of Restriction: _____ Date: ___/___/___

Description: _____

_____

_____

_____

_____

20. Withdrawal or Denial of License

State: _____ Year: _____

Description: _____

_____

_____

21. Liability Insurance Actions

Name of Organization taking Action: _____ Date: ___/___/___

Duration: _____

Description: _____

_____

_____

_____

22. Medical Condition:

Medical Condition: _____

_____

_____

_____

23. Chemical Dependency

Treating Organization: _____

Address: _____

Person Responsible for Treatment: _____

Type of Condition and Treatment: _____

_____

_____

24. Practice Limitation

Description: _____

_____

_____

_____

Signature: _____ **Date**: ___/___/___